SURGERY
ELECTRONIC SIGNATURE FOR OPERATIVE REPORTS

IMPLEMENTATION GUIDE

SR*3*100

Version 3.0
April 2004

Department of Veterans Affairs
V*IST***A** Health Systems Design & Development

Revision History

Each time this manual is updated, the Title Page lists the new revised date and this page describes the changes. Either update the existing manual with the Change Pages document, or replace it with the updated manual.

Note: The Change Pages document may include unedited pages needed for two-sided copying. Only edited pages display the patch number and revision date in the page footer.

Date	Revised Pages	Patch Number	Description
04/04	All	SR*3*100	Includes descriptions and examples of enhancements made to the Operation Report, Nurse Intraoperative Report, Anesthesia Report, and the Procedure Report (Non-O.R).

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Introduction

The Surgery Electronic Signature for Operative Reports project provides the ability to electronically sign operative reports contained within the Veterans Health Information Systems and Technology Architecture (**V***IST***A**) Surgery software. In addition, it provides the ability to view these signed reports using the Computerized Patient Record System (CPRS), by storing them within the Text Integration Utilities (TIU) package. The new functionality is applied to the Operation Report, the Nurse Intraoperative Report, the Anesthesia Report, and the Procedure Report (Non-O.R.).

Documentation Conventions

This Implementation Guide includes documentation conventions, also known as notations, which are used consistently throughout this manual. Each is outlined below.

Convention	Example
Menu option text is italicized.	The *Print Surgery Waiting List* option generates the long form surgery Waiting List for the surgical service(s) selected.
Screen prompts are denoted with quotation marks around them.	The "Puncture Site:" prompt will display next.
Responses in **bold face** indicate user input.	Needle Size: **25G**
Text centered between arrows represents a keyboard key that needs to be pressed for the system to capture a user response or to move the cursor to another field. <Enter> indicates that the Enter key (or Return key on some keyboards) must be pressed. <Tab> indicates that the Tab key must be pressed.	Type **Y** for Yes or **N** for No, and then press **<Enter>**. Press **<Tab>** to move the cursor to the next field.
 Indicates especially important or helpful information.	 If the user attempts to reschedule a case after the schedule close time for the date of operation, only the time, and not the date, can be changed.
 Indicates that options are locked with a particular security key. The user must hold the particular security key to be able to perform the menu option.	 Without the SROAMIS key the *Anesthesia AMIS* option cannot be accessed.

Getting Help and Exiting

?, ??, **???** One, two or three question marks can be entered at any of the prompts for online help. One question mark elicits a brief statement of what information is appropriate for the prompt. Two question marks provide more help, plus the hidden actions, and three question marks will provide more detailed help, including a list of possible answers, if appropriate.

Typing the up arrow ^ (caret or a circumflex) and pressing **<Enter>** can be used to exit the present option.

Using This Manual

This manual is a valuable resource for learning about the new features provided by the Surgery Electronic Signature for Operative Reports project. This guide an be used as a learning tool, providing both instructional text and a step-by-step walkthrough of the changes affecting the Operation Report, the Nurse Intraoperative Report, the Anesthesia Report, and the Procedure Report (Non-O.R.).

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Creating Electronic Signature Codes

A primary aspect of security in many **V*IST*A** packages involves the use of Electronic Signature codes. Users who have the authority to approve actions, at any level, can enter and edit their own Electronic Signature code. The electronic signature of the report's author is required before information about the surgical reports can be viewed within CPRS.

Like the access and verify codes used when gaining access to the system, the Electronic Signature code will not be visible on the terminal screen. These codes are also encrypted so that even those individuals with the highest levels of access cannot view them through VA File Manager options.

The *Electronic Signature code Edit* option contained within the Kernel *User's Toolbox* menu option can be used to create or edit the Electronic Signature Code. An Electronic Signature can be changed at any time, much like the Verify Code.

Example: Editing an Electronic Signature Code

```
Select User's Toolbox Option:  Electronic Signature code Edit
This option is designed to permit you to enter or change your Initials,
Signature Block Information, Office Phone number, and Voice and
Digital Pagers numbers.
In addition, you are permitted to enter a new Electronic Signature Code
or to change an existing code.


INITIAL: SM
SIGNATURE BLOCK PRINTED NAME: Steve Miami
SIGNATURE BLOCK TITLE:
OFFICE PHONE: 555-943-2224
VOICE PAGER:
DIGITAL PAGER:

Enter your Current Signature Code:    SIGNATURE VERIFIED

Your typing will not show.
ENTER NEW SIGNATURE CODE:
DONE
```

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Operation Report

The following scenarios demonstrate how to use both the CPRS and List Manager options to electronically sign the Operation Report. Each scenario includes instructions and screen captures to aid the user in understanding the Electronic Signature process.

The first scenario provides instructions and screen captures related to viewing, editing, and electronically signing the Operation Report using the CPRS options.

The second scenario demonstrates how the List Manager options can also be used to view, edit, and electronically sign the Operation Report.

If the *Operation Report* option within the Surgery software is used to display the report, one of the following scenarios will occur.

- If the dictated Operation Report is not yet signed, the following statement displays: "The Operation Report for this case is not yet available."

- If the Operation Report has been signed, it will be preceded with the statement, "The following Operation Report has been electronically signed." The electronically signed Operation Report is then displayed.

(This page included for two-sided copying.)

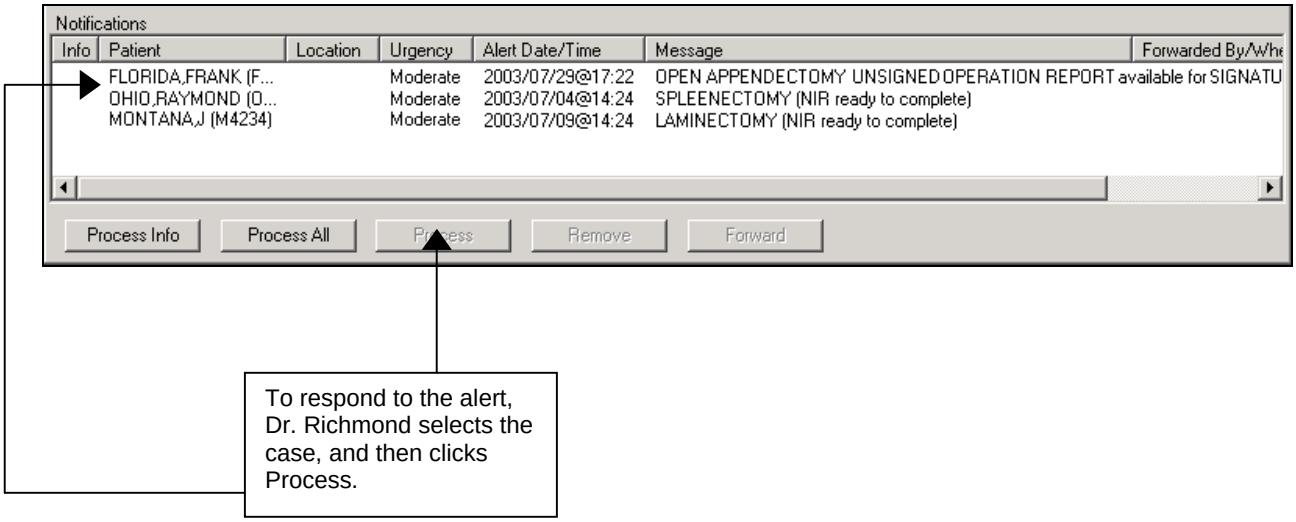
Scenario 1: Using CPRS Options

The following scenario uses the CPRS options to demonstrate different methods of viewing, signing, and editing an Operation Report.

Signing the Operation Report

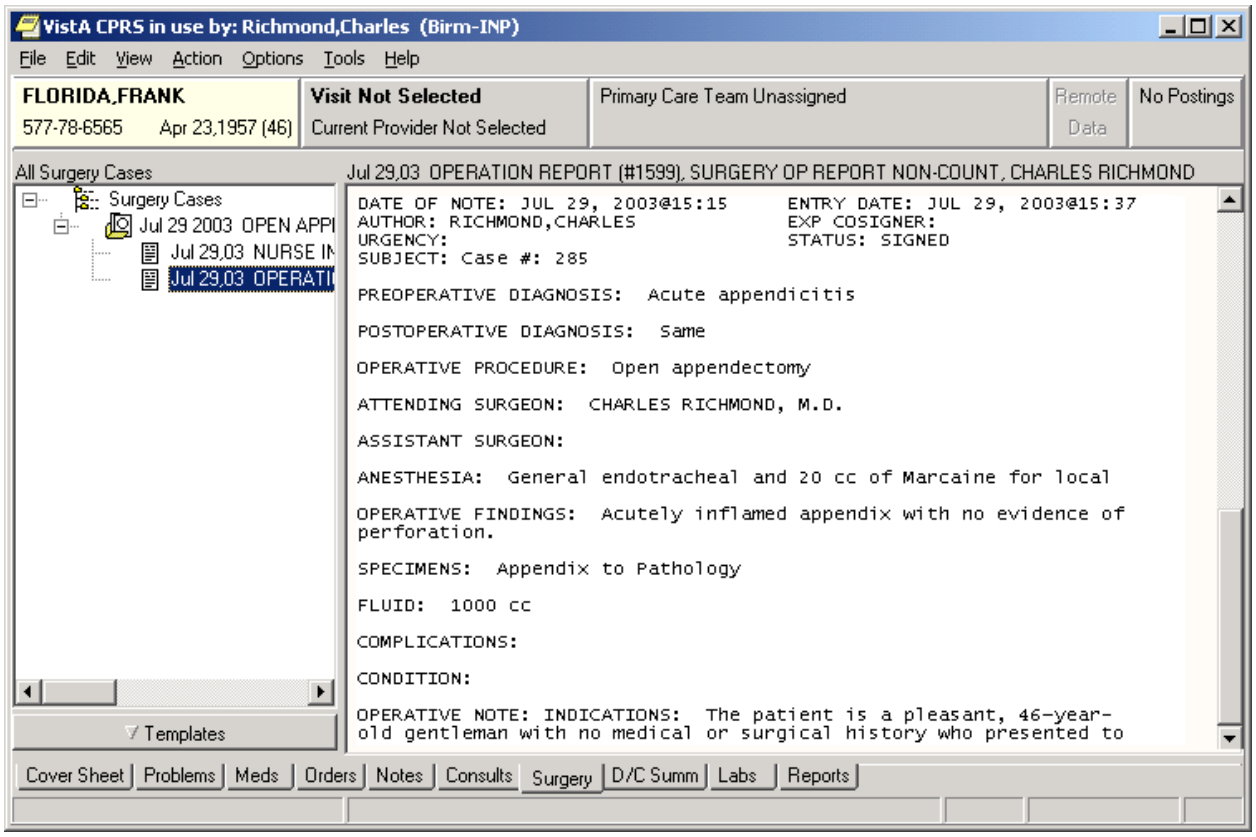
General surgery was performed on Frank Florida. Upon completion of the case, the surgeon, Dr. Charles Richmond, dictates his Operation Report. After the report is transcribed, it is uploaded into TIU and an alert is sent to Dr. Richmond notifying him that the Operation Report is ready for signature.

Example: Viewing the Ready for Signature Alert



By responding to the alert, Dr. Richmond automatically accesses the new CPRS Surgery tab. The Surgery tab opens with the Surgery case selected and the report open.

Example: Responding to the Alert Sends the Surgeon to the Surgery Tab

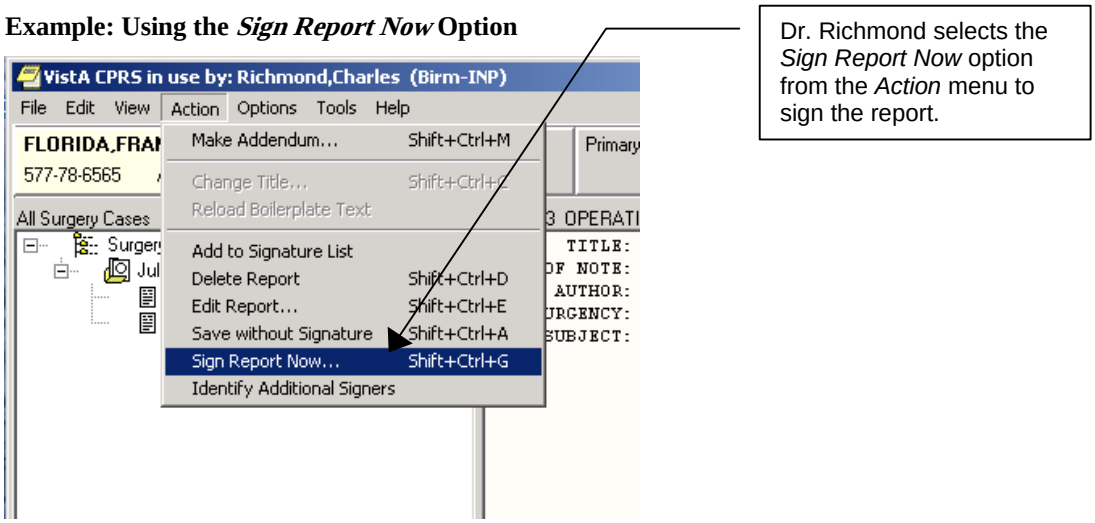


Dr. Richmond reviews the information on the report. If there were any errors in his Operation Report, he would make the updates using the *Edit Report* option from the *Action* menu. After signature, errors can be corrected by creating an addendum to the report.

The *Edit Report* option is also accessible by right-clicking in the document pane.

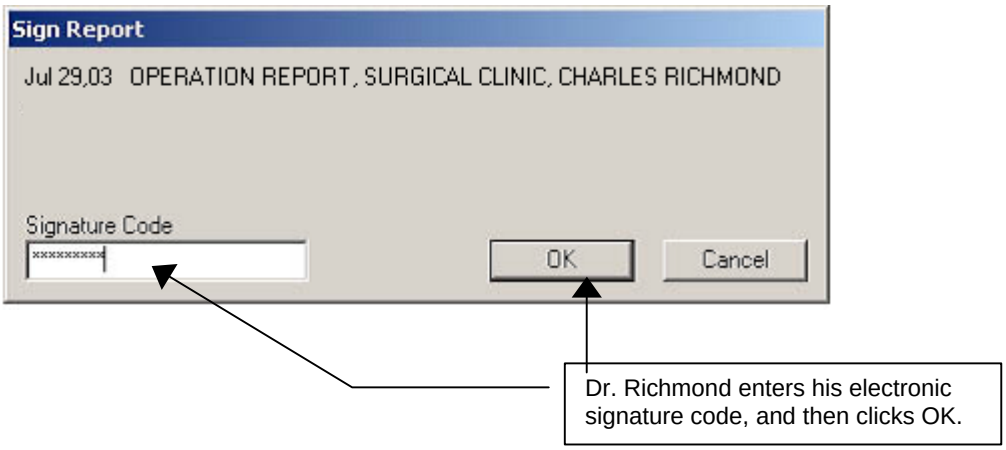
Dr. Richmond reviews the unsigned dictated Operation Report and decides that it is correct and ready for his signature. Using the *Sign Report Now* option from the *Action* menu, he electronically signs the Operation Report.

Example: Using the *Sign Report Now* Option



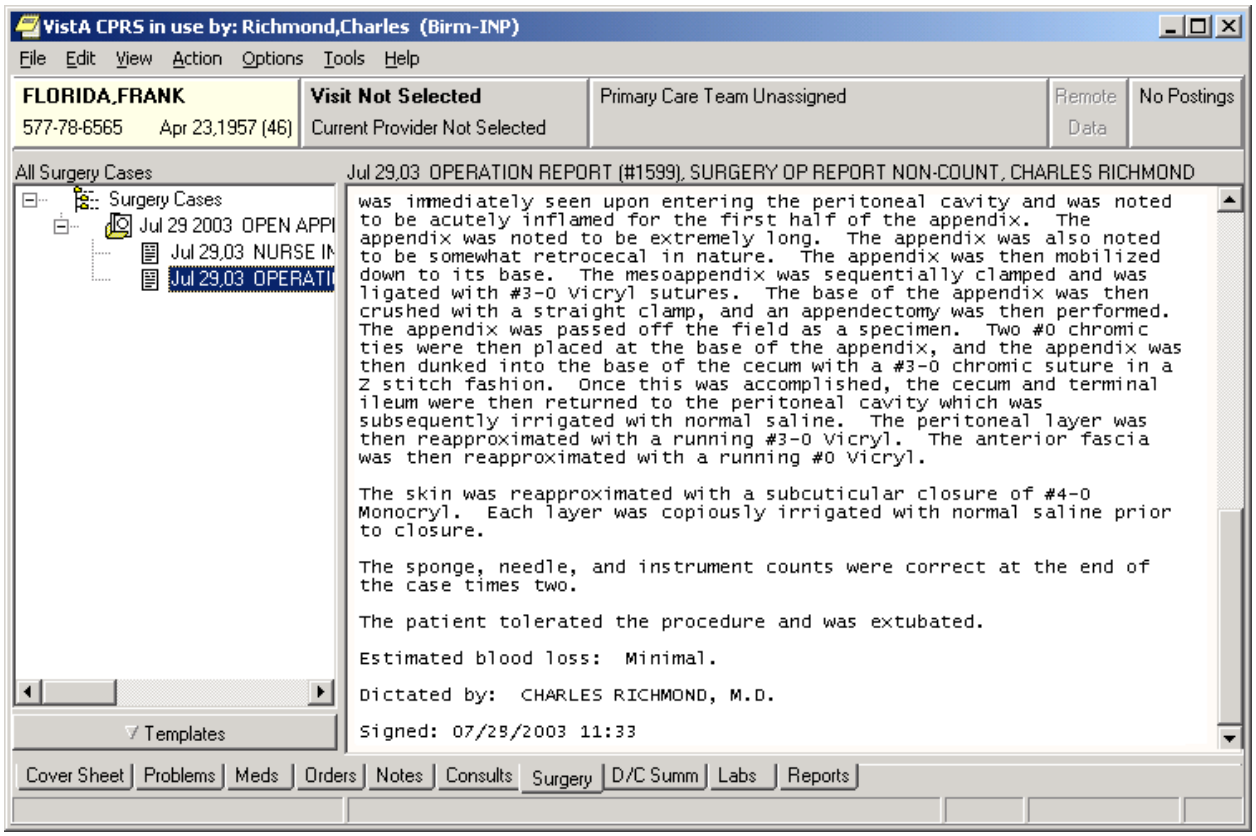
Next, Dr. Richmond is prompted to enter his electronic signature code.

Example: Entering an Electronic Signature Code



After the report is signed, it is viewable to other users on the Surgery tab in CPRS, based on the business rules at each facility.

Example: Viewing the Operation Report on the CPRS Surgery Tab

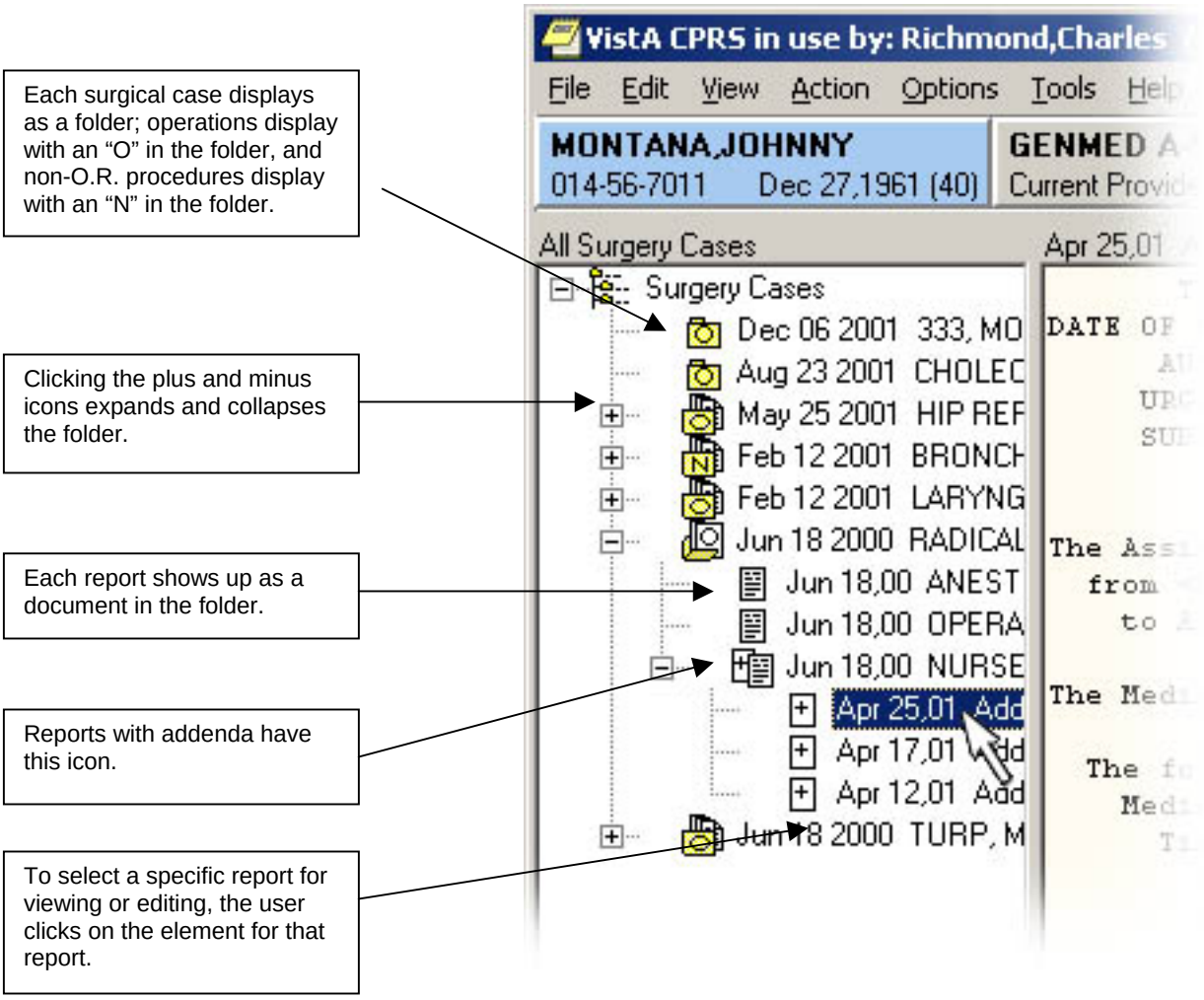


Creating an Addendum for the Operation Report

Later that day, Nurse Emily Lansing informs Dr. Richmond that the end time he entered in the text of his Operation Report is incorrect. To review this information, he uses the Surgery tab in CPRS. On the Surgery tab, all of the patient's cases are listed chronologically by date of operation.

The example on this page shows the expanded tree view of a *different* patient. This patient has several surgery cases and reports.

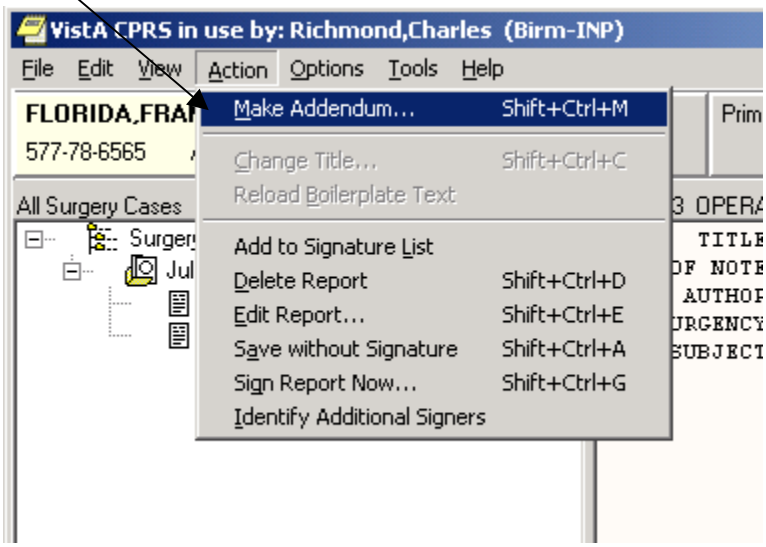
Example: Selecting the Patient's Operation and the Report



After reviewing the discrepancy in the Operation Report and the end time as reported by Nurse Lansing, Dr. Richmond realizes he made an error in the report and needs to correct it. Because the Operation Report has already been signed, he must create an addendum to the report using the *Make Addendum* option from the *Action* menu.

Example: Selecting the *Make Addendum* Option

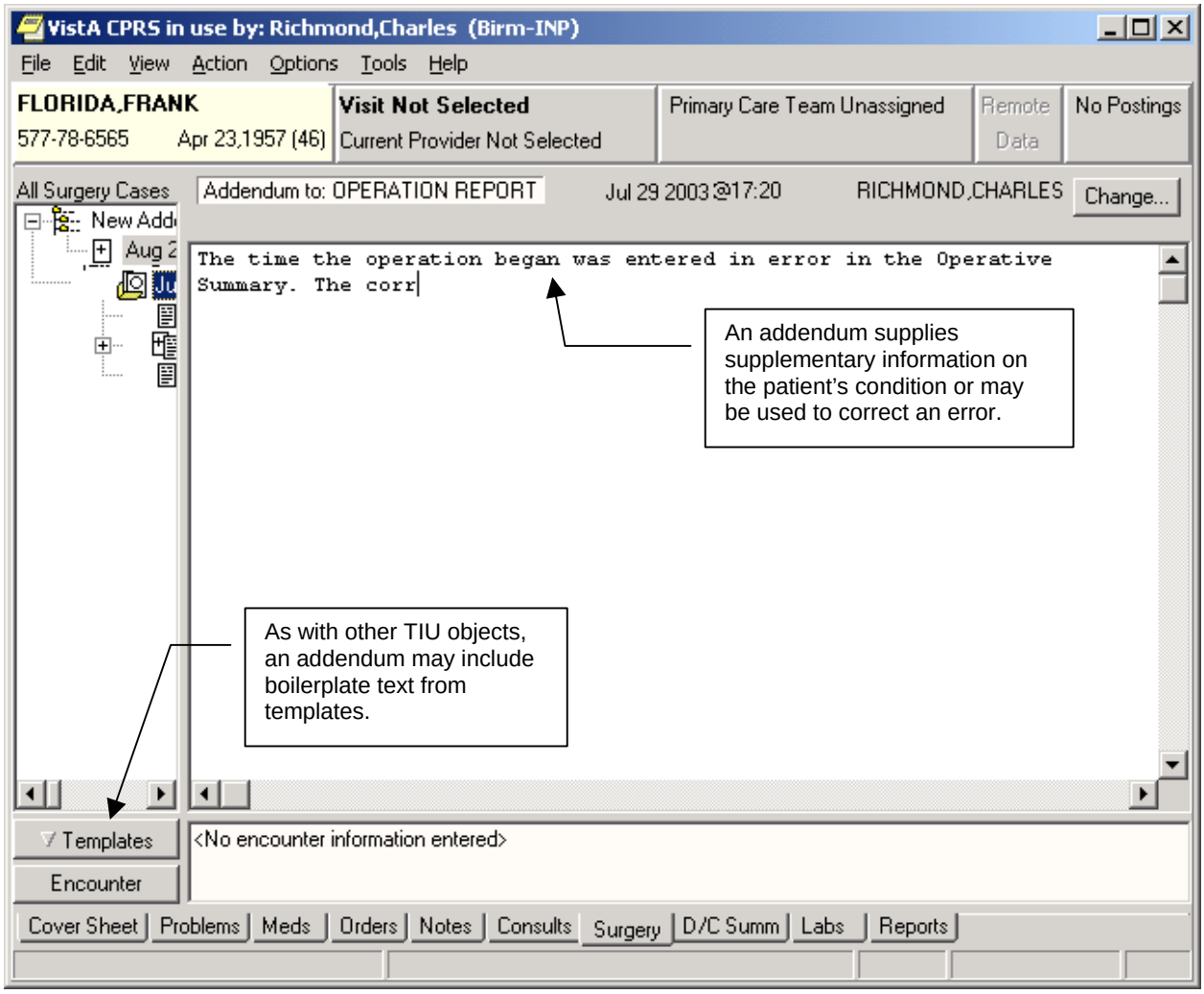
Dr. Richmond chooses the *Make Addendum* option from the *Action* menu to add an addendum.



The *Make Addendum* option is also accessible by right-clicking in the document pane.

Dr. Richmond edits the text of the Operation Report.

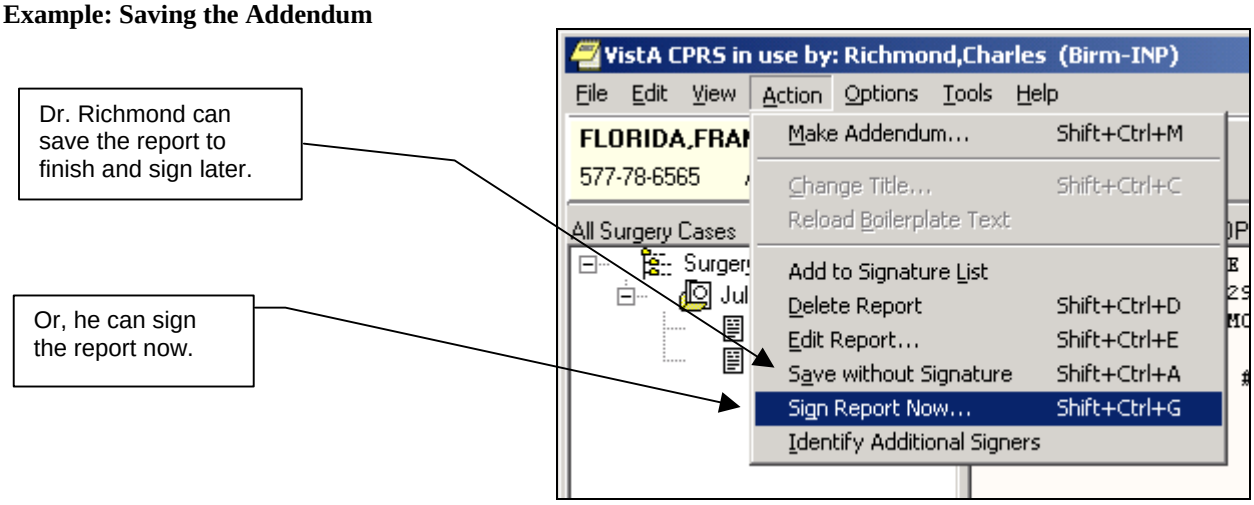
Example: Creating the Text for the Addendum



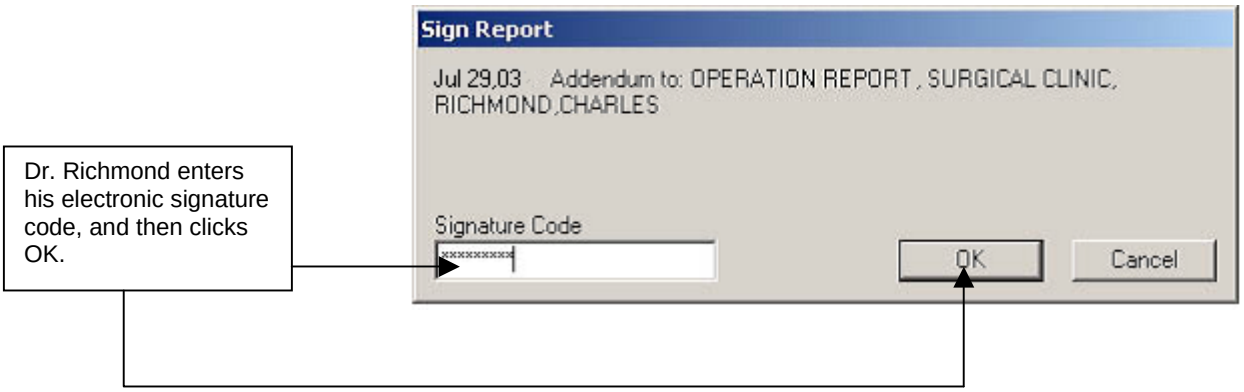
When the user saves the addendum, CPRS automatically stores the addendum creation date and time. Another date and time is generated when the addendum is signed, and again when it is cosigned.

Dr. Richmond may sign the addendum now, or choose to save it without signing it. However, an addendum will not display on the Operation Report unless it is electronically signed, or your facility allows for viewing unsigned documents based on your business rules.

Example: Saving the Addendum

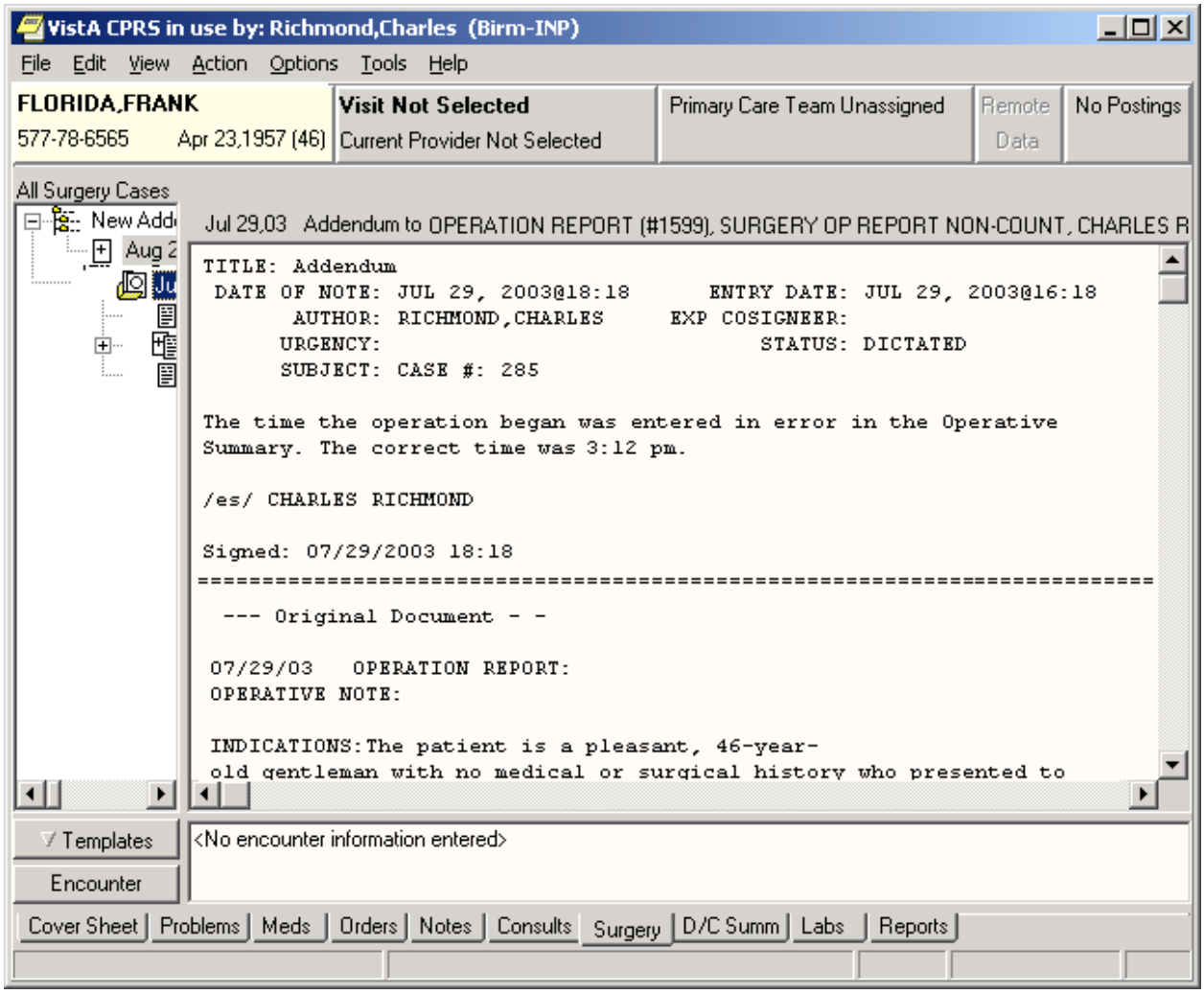


Knowing that the only discrepancy has now been corrected, Dr. Richmond selects the *Sign Report Now* option from the *Action* menu.



A signed addendum always displays when a user views or prints the Operation Report.

Example: Viewing the Operation Report After the Addendum is Created



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Scenario 2: Using List Manager Options

The following scenario uses the List Manager options to demonstrate different methods of viewing, signing, and editing an Operation Report.

Signing the Operation Report

Using the List Manager options to edit, sign, and add addenda to the Operation Report is similar to the process used in Scenario 1 of this section. The process begins when Dr. Richmond receives an alert.

Example: Viewing the Ready for Signature Alert

```
1.   FLORIDA,F (F3021): UNSIGNED OPERATIVE REPORT available for SIGNATURE.
2.   KANSAS,T (M7689): Cancelled consult CAR
3.   ARIZONA,A (S5656): Order requires electronic signature.
          Select from 1 to 3
          or enter ?, A, F, S, P, M, R, or ^ to exit: 1

FLORIDA,FRANK        4-23-57    577786565     YES     SC VETERAN
            (26 notes)  C: 09/15/99 09:24  (amended 10/01/99 08:37)
            (1 note )  W: 02/21/97 09:19
            (9 notes)  D: 06/14/99 13:32
                       A: Known allergies
 Enrollment Priority: GROUP 1    Category: IN PROCESS    End Date:


Opening OPERATIVE REPORT record for review...
```

By responding to the alert, Dr. Richmond is sent to the TIU Browse mode with the Operation Report opened. He can then edit the report by accessing the *TIU List Manager* option.

Example: Editing the Operation Report

```
Browse Document               Jul 30, 2003 15:53:20                Page:    1 of    4
                                 OPERATION REPORT
FLORIDA,FRANK        577-78-6565   2B MED            Adm: 06/25/2003  Dis:         _

SURGICAL CASE #: 189
_____________________________________________________________________________
INDICATIONS:
The patient is a pleasant, 46-year-
old gentleman with no medical or surgical history who presented to
the VA hospital with the chief concern with abdominal pain associated
with nausea.

PATHOLOGICAL FINDINGS:
He stated that the pain had started approximately 10:00
to 10:30 in the morning and was initially diffuse and associated with
a lot of nausea.  It subsequently localized to the right lower quadrant
at which time he began having chills but no fevers.  He denied having
any diarrhea.  The presumptive diagnosis of appendicitis, and he was
brought to the Operating Room.

PROCEDURE:
The patient was brought to the Operating Room and placed
in the supine position on the table.  Venodyne boots were placed on
bilateral lower extremities as were cardiopulmonary monitoring devices.
General endotracheal anesthesia was then established, and the patient
was prepped and draped in the standard sterile fashion.  A right lower
quadrant modified Rocky-Davis incision was then made and brought down
through the skin and subcutaneous tissues.  The anterior fascia was
identified and transected.  The rectus muscle was then identified and
<=======T=======T=======T=======T=======T=======T=======T=======T=======T>======

+         + Next Screen  - Prev Screen  ?? More actions                    >>>
       Find                     Sign/Cosign              Link ...
       Print                    Copy                     Encounter Edit
       Edit                     Identify Signers         Interdiscipl'ry Note
       Make Addendum            Delete                   Quit
Select Action: Next Screen// ED  Edit
```

```
HOSPITAL LOCATION: 5 WEST PSYCH// <Enter>
DATE/TIME OF NOTE: JUL 30,2003@06:45// <Enter>
AUTHOR OF NOTE: RICHMOND,CHARLES// <Enter>
SUBJECT (OPTIONAL description): TEST// <Enter>

No cosignature is required for this author.

SUBJECT (OPTIONAL description): Case #: 189// <Enter>

Calling text editor, please wait...
```

```
==[ WRAP ]==[ INSERT ]=======< Patient: FLORIDA,FRANK >======[ <PF1>H=Help ]====

INDICATIONS:
The patient is a pleasant, 46-year-
old gentleman with no medical or surgical history who presented to
the VA hospital with the chief concern with abdominal pain associated
with nausea.

PATHOLOGICAL FINDINGS:
He stated that the pain had started approximately 10:00
to 10:30 in the morning and was initially diffuse and associated with
a lot of nausea.  It subsequently localized to the right lower quadrant
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any diarrhea.  The presumptive diagnosis of appendicitis, and he was
brought to the Operating Room.

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in the supine position on the table.  Venodyne boots were placed on
bilateral lower extremities as were cardiopulmonary monitoring devices.
General endotracheal anesthesia was then established, and the patient
was prepped and draped in the standard sterile fashion.  A right lower
quadrant modified Rocky-Davis incision was then made and brought down
through the skin and subcutaneous tissues.  The anterior fascia was
identified and transected.  The rectus muscle was then identified and
<=======T=======T=======T=======T=======T=======T=======T=======T=======T>======

Saving OPERATION REPORT with changes...
```

After determining that the report is correct, Dr. Richmond electronically signs the report.

Example: Electronically Signing the Report

```
Enter your Current Signature Code:      SIGNATURE VERIFIED...
Print this note? No// Y  YES
DEVICE: HOME// SURG HP LJ 8100

Continue (Y/N) or (F)orward or (R)enew YES// <Enter>

 1.   KANSAS,T (M7689): Cancelled consult CAR
 2.   ARIZONA,A (S5656): Order requires electronic signature.
          Select from 1 to 2
          or enter ?, A, F, S, P, M, R, or ^ to exit: <Enter>

   OE     CPRS Clinician Menu
   RR     Results Reporting Menu
   AD     Add New Orders
   RO     Act On Existing Orders
   PP     Personal Preferences ...


You have PENDING ALERTS
          Enter  "VA   VIEW ALERTS     to review alerts

Select Clinician Menu Option:
```

When typing the electronic signature code, no characters will display on the screen.

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Creating an Addendum for the Operation Report

Once a report is signed, any provider may add an addendum. The original author could add information that was inadvertently left out, or that has come to light since the report was written. Also, another provider, who has enlightening knowledge about the subject of the note, might add an addendum.

The easiest way to add an addendum to any note is through CPRS, as noted earlier in this document. However, another way to add an addendum is through the TIU *Multiple Patient Documents* option, as shown in the following example.

Example: Using the *Integrated Document Management* Option

```
Select OPTION NAME: TIU MAIN MENU CLINICIAN       Progress Notes/Discharge Summary [TIU]

                           --- Clinician's Menu ---

   1      Progress Notes User Menu ...
   2      Discharge Summary User Menu ...
   3      Integrated Document Management ...
   4      Personal Preferences ...

Select Progress Notes/Discharge Summary [TIU] Option: INtegrated Document Management

                           --- Clinician's Menu ---

   1      Individual Patient Document
   2      All MY UNSIGNED Documents
   3      Multiple Patient Documents
   4      Enter/edit Document

Select Integrated Document Management Option:
```

Dr. Richmond can choose either the *Individual Patient Document* option or the *Multiple Patient Documents* option to create his addendum. In this case, he chooses to select the *Multiple Patient Documents* option.

Example: Using the *Multiple Patient Documents* Option

```
Select Integrated Document Management Option: 3 Multiple Patient Documents

Select Status: COMPLETED// <Enter> completed

Select CLINICAL DOCUMENTS Type(s): Surgical Reports// <Enter> Surgical Reports

Select SEARCH CATEGORIES: AUTHOR// PAT   Patient
Select PATIENT: FLORIDA,FRANK  FLORIDA,FRANK        4-23-57     WHITE, NOT OF HI
SPANIC ORIGIN    577786565     YES     SC VETERAN           SMB     SMB
            (2 notes)   C: 08/31/95 16:09
                        A: Known allergies
Start Reference Date [Time]: T-7// <Enter>    (JUL 20, 2003)
Ending Reference Date [Time]: NOW// <Enter>   (JUL 31, 2002@11:39)

Searching for the documents.
```

```
Clinical Documents            Jul 31, 2003@13:33:48          Page:    1 of    1
             by PATIENT (FLORIDA,FRANK) from 07/20/03 to 07/31/03   3 documents
     Patient                Document                          Ref Date  Status    .
1    + FLORIDA,F    (F3333) NURSE INTRAOPERATIVE REPORT       07/29/03  completed
2    FLORIDA,F      (F3333) OPERATION REPORT                  07/29/03  completed
3    FLORIDA,F      (F3333) ANESTHESIA REPORT                 07/29/03  completed

          + Next Screen  - Prev Screen  ?? More Actions                    >>>
     Add Document              Detailed Display          Delete Document
     Edit                      Browse                    Interdiscipl'ry Note
     Make Addendum             Print                     Expand/Collapse Entry
     Link ...                  Identify Signers          Encounter Edit
     Sign/Cosign               Change View               Quit
Select Action: Quit// 2
```

The plus sign before the patient's name indicates that one or more addenda exist for the document. The *Expand/Collapse Entry* action can be used to view a list of these addenda.

At the bottom of the screen, Dr. Richmond types a **2**, the number of the report he wishes to edit. Now that the correct report (in this case the Operation Report) is selected, the *Make Addendum* option is used to create the addendum.

Example: Using the *Make Addendum* Option

```
Clinical Documents            Jul 31, 2003@13:33:48          Page:    1 of    1
             by PATIENT (FLORIDA,FRANK) from 07/20/03 to 07/31/03   3 documents
     Patient                Document                          Ref Date  Status    .
1    + FLORIDA,F    (F3333) NURSE INTRAOPERATIVE REPORT       07/29/03  completed
2    FLORIDA,F      (F3333) OPERATION REPORT                  07/29/03  completed
3    FLORIDA,F      (F3333) ANESTHESIA REPORT                 07/29/03  completed

          + Next Screen  - Prev Screen  ?? More Actions                    >>>
     Add Document              Detailed Display          Delete Document
     Edit                      Browse                    Interdiscipl'ry Note
     Make Addendum             Print                     Expand/Collapse Entry
     Link ...                  Identify Signers          Encounter Edit
     Sign/Cosign               Change View               Quit
Select Action: Quit// MA
```

```
Making an addendum for #2

Adding ADDENDUM
HOSPITAL LOCATION: 5 WEST PSYCH//  <Enter>
DATE/TIME OF NOTE: 07/29/03@14:14//   (JUL 29, 2003@14:14:00)

AUTHOR OF NOTE: RICHMOND,CHARLES//<Enter>      SALT LAKE CITY     UTAH     CDR



Calling text editor, please wait...

==[ WRAP ]==[ INSERT ]=======< Patient: FLORIDA,FRANK >======[ <PF1>H=Help ]===
The time the operation ended was entered in error in the Operation Report. The
correct time was 3:12 pm.









<=======T=======T=======T=======T=======T=======T=======T=======T=======T>=====

Saving Addendum with changes...

Enter your Current Signature Code:    SIGNATURE VERIFIED...

Print this note? No// Y  YES
Rebuilding the list...
Do you want WORK copies or CHART copies? CHART// <Enter>
```

```
Clinical Documents            Jul 31, 2003@13:33:48          Page:    1 of    1
             by PATIENT (FLORIDA,FRANK) from 02/08/02 to 02/15/02   3 documents
     Patient               Document                          Ref Date  Status
1    + FLORIDA,F   (F3333) NURSE INTRAOPERATIVE REPORT     07/29/03  completed
2    + FLORIDA,F   (F3333) OPERATION REPORT                07/29/03  completed
3    FLORIDA,F     (F3333) ANESTHESIA REPORT               07/29/03  completed









          ** Item 2 addended. **                                              >>>
     Add Document             Detailed Display          Delete Document
     Edit                     Browse                    Interdiscipl'ry Note
     Make Addendum            Print                     Expand/Collapse Entry
     Link ...                 Identify Signers          Encounter Edit
     Sign/Cosign              Change View               Quit
Select Action: Quit// <Enter>   Quit
```

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Nurse Intraoperative Report

The circulating nurse on the case, or any other user holding the SROCHIEF security key, can electronically sign the Nurse Intraoperative Report only in the Surgery software.

The following scenarios demonstrate how to use the Surgery software to electronically sign the Nurse Intraoperative Report. Each scenario includes instructions and screen captures to aid the user in understanding the Electronic Signature process.

The first scenario provides instructions and screen captures related to viewing, editing, and electronically signing the Nurse Intraoperative Report using the Surgery software.

The second scenario demonstrates how the List Manager options can also be used to view, edit, and electronically sign the Nurse Intraoperative Report.

Signing the Nurse Intraoperative Report

General surgery was performed on Frank Florida. Upon completion of the case, the TIME PAT OUT OR field is entered, which triggers an alert that is sent to the nurse responsible for signing the report. Nurse Lansing, who is responsible for the case, receives the alert displayed below.

The Nurse Intraoperative Report also can be signed immediately after entering the TIME PAT OUT OR field, without accessing the alert the Nurse Intraoperative Report option is being used for data entry. Any of the following options used for entering the operation information will require that you sign your report through the alert:

I	Operation Information
SS	Surgical Staff
OS	Operation Startup
O	Operation
PO	Post Operation
OSS	Operation (Short Screen)

Example: Viewing the Ready for Signature Alert

```
1.   FLORIDA,FRANK (F3021) MVR (NIR ready to complete)
         Select from 1 to 1
         or enter ?, A, F, S, P, M, R, or ^ to exit: 1
```

By acting on the alert, Nurse Lansing automatically accesses the *Nurse Intraoperative Report* option to electronically sign the report. The prompt, "Press <return> to continue, 'A' to access Nurse Intraoperative Report functions, or '^' to exit:" displays at the bottom of the screen.

Example: Viewing the First Page of the Nurse Intraoperative Report

```
FLORIDA,FRANK (577-78-6565)
   MEDICAL RECORD       NURSE INTRAOPERATIVE REPORT - CASE #285          PAGE 1

Operating Room:  ORI                    Surgical Priority: EMERGENCY

Patient in Hold: JUL 29, 2003  15:00    Patient in OR:  JUL 29, 2003  15:07
Operation Begin: JUL 29, 2003  15:20    Operation End:  JUL 29, 2003  16:27
Surgeon in OR:   JUL 29, 2003  15:10    Patient Out OR: JUL 29, 2003  16:54

Major Operations Performed:
Primary: OPEN APPENDECTOMY

Wound Classification: CLEAN
Operation Disposition: N/A
Discharged Via: N/A

Surgeon: RICHMOND,CHARLES               First Assist: N/A
Attend Surg: RICHMOND,CHARLES           Second Assist: N/A
Anesthetist: ATHENS,DEBBIE              Assistant Anesth: N/A

Other Scrubbed Assistants: N/A

 Press <return> to continue, 'A' to access Nurse Intraoperative Report
 functions, or '^' to exit: A
```

Several key fields are required before the Surgery software will allow Nurse Lansing to electronically sign the Nurse Intraoperative Report. If any of these fields are left blank, a message will display, prompting the user to provide the missing information.

The Nurse Intraoperative Report must have the TIME PAT IN OR field and the TIME PAT OUT OR field entered. Additionally, because the COUNTS VERIFIED BY field has been entered, the SPONGE COUNT CORRECT (Y/N) field, SHARPS COUNT CORRECT (Y/N) field, INSTRUMENT COUNT CORRECT (Y/N) field, and the SPONGE, SHARPS, & INST COUNTER field must also be completed before the Nurse Intraoperative Report can be electronically signed. The TIME OUT VERIFIED and PREOPERATIVE IMAGING CONFIRMED fields are also required before this report can be electronically signed.

Nurse Lansing believes that the report is ready for signature. She enters an **A** at the "Press <return> to continue, 'A' to access Nurse Intraoperative Report functions, or '^' to exit:" prompt at the bottom of the screen. The *Nurse Intraoperative Report* functions display.

Example: Using the *Nurse Intraoperative Report* Functions

```
 FLORIDA,FRANK (577-78-6565)   Case #285 - JUL 29, 2003

 Nurse Intraoperative Report Functions:

  1. Edit report information
  2. Print/View report from beginning
  3. Sign the report electronically

Select number: 2// 3
```

Nurse Lansing types a **3**, *Sign the report electronically*. However, because the SHARPS COUNT CORRECT (Y/N) field has not been entered, the following message displays.

Example: Viewing the Missing Field Message

```
The following information is required before this report may be signed:

      SHARPS COUNT CORRECT (Y/N)

Do you want to enter this information? YES// NO
```

Before supplying the missing information, Nurse Lansing decides to print a hard copy of the report to review. She answers **NO** to the "Do you want to enter this information? YES//" prompt, then selects the *Print/View report from beginning* function (#2) and prints out the unsigned report.

Example: Printing the Unsigned Report

```
FLORIDA,FRANK (577-78-6565)   Case #285 - JUL 29, 2003

 Nurse Intraoperative Report Functions:

  1. Edit report information
  2. Print/View report from beginning
  3. Sign the report electronically

Select number: 2// <Enter>  2  Print/View report from beginning
```

```
FLORIDA,FRANK (577-78-6565)
   MEDICAL RECORD       NURSE INTRAOPERATIVE REPORT - CASE #285          PAGE 1

Operating Room:  OR1                    Surgical Priority: EMERGENCY

Patient in Hold: JUL 29, 2003  15:00    Patient in OR:  JUL 29, 2003  15:07
Operation Begin: JUL 29, 2003  15:20    Operation End:  JUL 29, 2003  16:27
Surgeon in OR:   JUL 29, 2003  15:10    Patient Out OR: JUL 29, 2003  16:54

Major Operations Performed:
Primary: OPEN APPENDECTOMY

Wound Classification: CLEAN
Operation Disposition: N/A
Discharged Via: N/A

Surgeon: RICHMOND,CHARLES               First Assist: N/A
Attend Surg: RICHMOND,CHARLES           Second Assist: N/A
Anesthetist: ATHENS,DEBBIE              Assistant Anesth: N/A.



       [Fields not displayed to save space in the example.]



Sponge Count:       YES
Sharps Count:   ***Not Entered***
Instrument Count:   YES




 (Example abbreviated. The actual report contains more information.)
```

After reviewing the printed report, Nurse Lansing sees that only the SHARPS COUNT CORRECT (Y/N) field information has been omitted. She uses the *Edit report information* function (#1) to add the missing information.

If any other information had been incorrect, Nurse Lansing would use the *Edit report information* function (#1) to edit any of the fields on the Nurse Intraoperative Report.

Example: Editing the Nurse Intraoperative Report

```
FLORIDA,FRANK (577-78-6565)   Case #285 - JUL 29, 2003

 Nurse Intraoperative Report Functions:

  1. Edit report information
  2. Print/View report from beginning
  3. Sign the report electronically

Select number: 2// 1  Edit report information
```

After selecting the *Edit report information* function (#1) to update the information, Nurse Lansing makes the correction.

Example: Correcting the Nurse Intraoperative Report

```
** NURSE INTRAOP **   CASE #285  FLORIDA,FRANK PAGE 1 OF 5

1    SPONGE COUNT CORRECT (Y/N): YES
2    SHARPS COUNT CORRECT (Y/N):
3    INSTRUMENT COUNT CORRECT (Y/N): NOT APPLICABLE
4    SPONGE, SHARPS, & INST COUNTER: MIAMI,STEVE
5    COUNT VERIFIER:
6    TIME PAT IN HOLD AREA: JUL 29, 2003 AT 15:00
7    TIME PAT IN OR:     JUL 29, 2003 AT 15:07
8    MARKED SITE CONFIRMED: YES
9    PREOPERATIVE IMAGING CONFIRMED: YES
10   TIME OUT VERIFIED: YES
11   CORRECT SURGERY COMMENTS: (WORD PROCESSING)
12   TIME OPERATION BEGAN: JUL 29, 2003 AT 15:20
13   TIME OPERATION ENDS: JUL 29, 2003 AT 16:2
14   SURG PRESENT TIME: JUL 29, 2003 AT 15:10
15   TIME PAT OUT OR: JUL 29, 2003 AT 16:54

Enter Screen Server Function:  2
Final Sharps Count Correct (Y/N): YES
```

```
** NURSE INTRAOP **   CASE #285  FLORIDA,FRANK PAGE 1 OF 5

1    SPONGE COUNT CORRECT (Y/N): YES
2    SHARPS COUNT CORRECT (Y/N): YES
3    INSTRUMENT COUNT CORRECT (Y/N): NOT APPLICABLE
4    SPONGE, SHARPS, & INST COUNTER: MIAMI,STEVE
5    COUNT VERIFIER:
6    TIME PAT IN HOLD AREA: JUL 29, 2003 AT 15:00
7    TIME PAT IN OR:     JUL 29, 2003 AT 15:07
8    MARKED SITE CONFIRMED: YES
9    PREOPERATIVE IMAGING CONFIRMED: YES
10   TIME OUT VERIFIED: YES
11   CORRECT SURGERY COMMENTS: (WORD PROCESSING)
12   TIME OPERATION BEGAN: JUL 29, 2003 AT 15:20
13   TIME OPERATION ENDS: JUL 29, 2003 AT 16:2
14   SURG PRESENT TIME: JUL 29, 2003 AT 15:10
15   TIME PAT OUT OR: JUL 29, 2003 AT 16:54

Enter Screen Server Function: ^
```

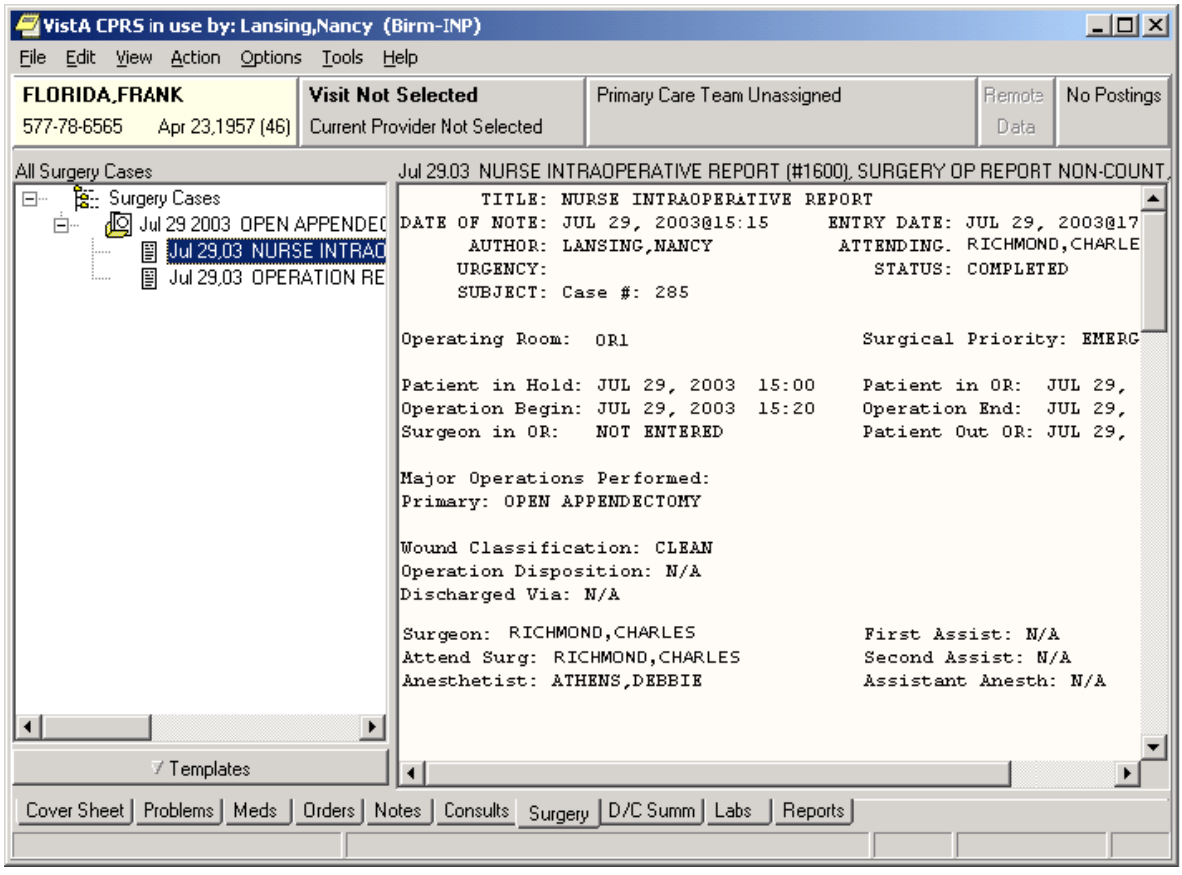
After correcting the SHARPS COUNT CORRECT (Y/N) field, the report is complete and ready for electronic signature. Nurse Lansing chooses the *Sign the report electronically* function (#3) and electronically signs the report.

Example: Electronically Signing the Nurse Intraoperative Report

```
FLORIDA,FRANK (577-78-6565)   Case #285 - JUL 29, 2003

 Nurse Intraoperative Report Functions:

  1. Edit report information
  2. Print/View report from beginning
  3. Sign the report electronically

Select number: 2// 3  Sign the report electronically

Enter your Current Signature Code:    SIGNATURE VERIFIED ..

Press RETURN to continue... <Enter>


 FLORIDA,FRANK (577-78-6565)   Case #285 - JUL 29, 2003

 * * The Nurse Intraoperative Report has been electronically signed. * *
```

Since this report has been signed, it is now viewable through the CPRS Surgery tab.

Example: Viewing the Report on the CPRS Surgery Tab



Creating an Addendum for the Nurse Intraoperative Report

After signing the Nurse Intraoperative Report, Nurse Lansing notices that the wound classification was not updated from CLEAN to CONTAMINATED. To edit the field and correct the information, she can access the *Operation Menu* option and use either the *Nurse Intraoperative Report* option or the *Post Operation* option. Nurse Lansing chooses the *Nurse Intraoperative Report* option.

Because the report was previously signed, the Surgery software does not display the first page of the Nurse Intraoperative Report. Instead, a message displays informing her that this report was previously signed. She is then given the opportunity to either print or edit the report. Nurse Lansing chooses the *Edit report information* function (#1) to edit the report. She receives a warning that she will have to create an addendum if she wishes to edit the signed case.

Example: Using the *Nurse Intraoperative Report* Functions

```
 * * The Nurse Intraoperative Report has been electronically signed. * *

 Nurse Intraoperative Report Functions:

  1. Edit report information
  2. Print/View report from beginning

Select number: 2// 1  Edit report information
```

Example: Viewing a Warning Indicating the Report was Previously Signed

```
                                      >>>  WARNING  <<<

   Electronically signed reports are associated with this case.  Editing
   of data that appear on electronically signed reports will require the
   creation of addenda to the signed reports.

Enter RETURN to continue or '^' to exit: <Enter>
```

Nurse Lansing presses **<Enter>** and continues on to the Nurse Intraoperative Report.

Example: Viewing the Nurse Intraoperative Report

```
** NURSE INTRAOP **   CASE #285  FLORIDA,FRANK PAGE 1 OF 5

1    SPONGE COUNT CORRECT (Y/N): YES
2    SHARPS COUNT CORRECT (Y/N): YES
3    INSTRUMENT COUNT CORRECT (Y/N): NOT APPLICABLE
4    SPONGE, SHARPS, & INST COUNTER: MIAMI,STEVE
5    COUNT VERIFIER:
6    TIME PAT IN HOLD AREA: JUL 29, 2003 AT 15:00
7    TIME PAT IN OR:     JUL 29, 2003 AT 15:07
8    MARKED SITE CONFIRMED: YES
9    PREOPERATIVE IMAGING CONFIRMED: YES
10   TIME OUT VERIFIED: YES
11   CORRECT SURGERY COMMENTS: (WORD PROCESSING)
12   TIME OPERATION BEGAN: JUL 29, 2003 AT 15:20
13   TIME OPERATION ENDS: JUL 29, 2003 AT 16:2
14   SURG PRESENT TIME: JUL 29, 2003 AT 15:10
15   TIME PAT OUT OR: JUL 29, 2003 AT 16:54

Enter Screen Server Function:  <Enter>
```

```
** NURSE INTRAOP **   CASE #285  FLORIDA,FRANK PAGE 2 OF 5

1    PRINCIPAL PROCEDURE: OPEN APPENDECTOMY
2    OTHER PROCEDURES:   (MULTIPLE)
3    WOUND CLASSIFICATION:CLEAN
4    OP DISPOSITION:
5    MAJOR/MINOR:
6    OPERATING ROOM:
7    CASE SCHEDULE TYPE:
8    SURGEON:           RICHMOND,CHARLES
9    ATTEND SURG:CR
10   FIRST ASST:
11   SECOND ASST:
12   PRINC ANESTHETIST:
13   ASST ANESTHETIST:
14   OTHER SCRUBBED ASSISTANTS: (MULTIPLE)
15   OR SCRUB SUPPORT:   (MULTIPLE)

Enter Screen Server Function:  15
Wound Classification: CLEAN// CONTAMINATED  CONTAMINATED
```

```
** NURSE INTRAOP **   CASE #285    FLORIDA,FRANK PAGE 2 OF 5

1    PRINCIPAL PROCEDURE: OPEN APPENDECTOMY
2    OTHER PROCEDURES:   (MULTIPLE)
3    WOUND CLASSIFICATION: CONTAMINATED
4    OP DISPOSITION:
5    MAJOR/MINOR:
6    OPERATING ROOM:
7    CASE SCHEDULE TYPE:
8    SURGEON:           RICHMOND,CHARLES
9    ATTEND SURG:CR
10   FIRST ASST:
11   SECOND ASST:
12   PRINC ANESTHETIST:
13   ASST ANESTHETIST:
14   OTHER SCRUBBED ASSISTANTS: (MULTIPLE)
15   OR SCRUB SUPPORT:   (MULTIPLE)

Enter Screen Server Function: ^
```

Nurse Lansing selects #15, the WOUND CLASSIFICATION field, and changes the field from CLEAN to CONTAMINATED. Upon exiting the option, a warning displays informing her that her changes will require a signed addendum.

Example: Viewing an Automatic Addendum Warning

```
FLORIDA,FRANK (577-78-6565)   Case #285 - JUL 29, 2003

An addendum to each of the following electronically signed document(s) is
required:

          Nurse Intraoperative Report - Case #285

If you choose not to create an addendum, the original data will be restored
to the modified fields appearing on the signed reports.


Create addendum? YES// YES
```

At the "Create addendum? YES//" prompt, Nurse Lansing types a **Y** and proceeds to create the addendum. (If she selected NO, the information in that field would revert back to what was previously entered.) The addendum information is presented for her review.

Example: Viewing Addendum Information

```
Addendum for Case #285 – JUL 29, 2003
Patient: FLORIDA,FRANK (577-78-6565)
------------------------------------------------------------------------------

The Wound Classification field was changed
  from CLEAN
    to CONTAMINATED

Enter RETURN to continue or '^' to exit: <Enter>



Do you want to add a comment for this case? NO// <Enter>


Enter your Current Signature Code:    SIGNATURE VERIFIED..

Press RETURN to continue...
```

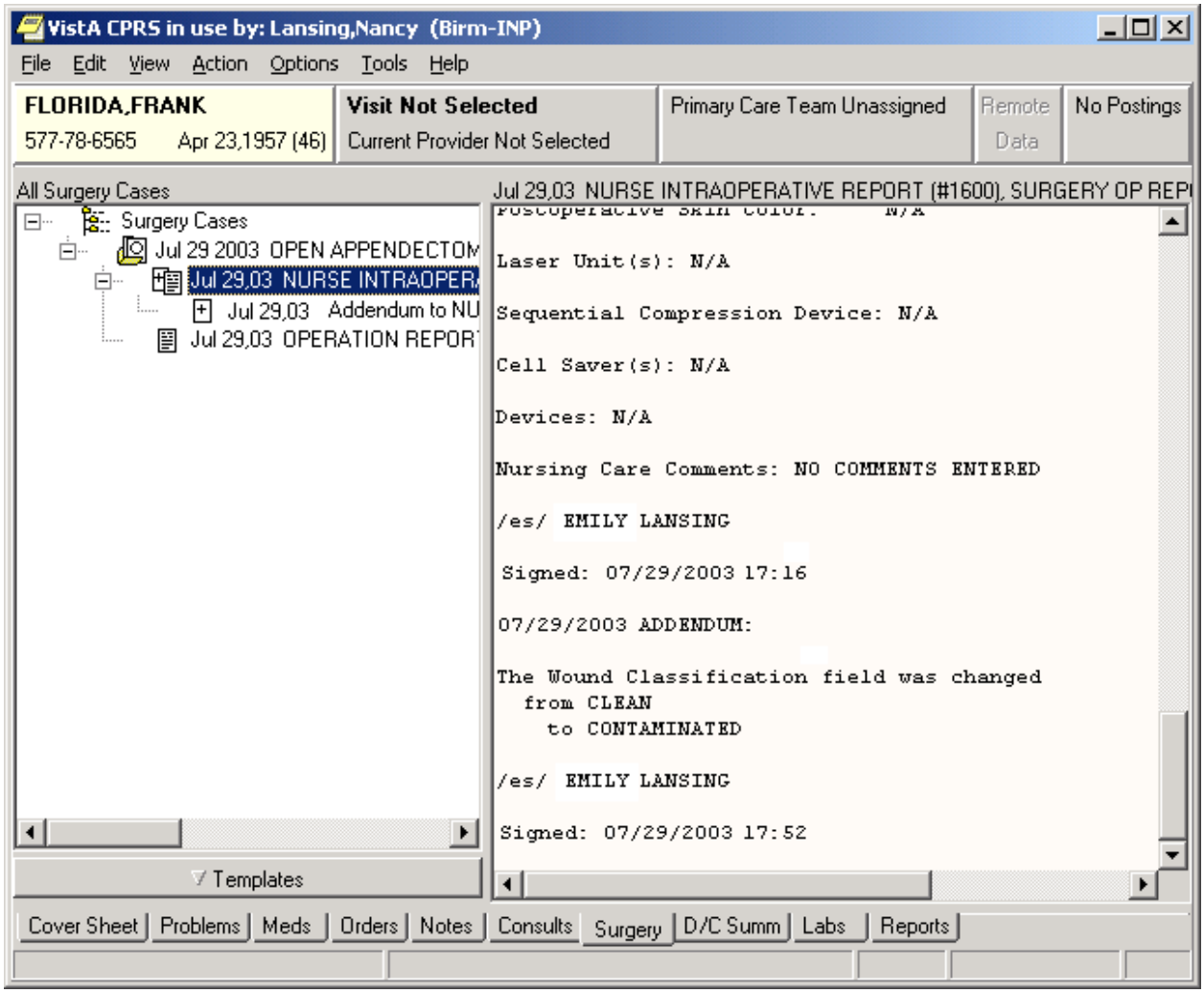
When typing the electronic signature code, no characters display on the screen.

After reviewing the automatic addendum for accuracy, she presses **<Enter>** and proceeds to electronically sign the addendum to the report. The Surgery software also allows her to enter additional comments if necessary.

If Nurse Lansing had edited information on the report by mistake, she could decline to sign the addendum and the information in that field would revert back to what was previously entered.

Following the electronic signature of the addendum, the report would display on the CPRS Surgery tab, as follows.

Example: Viewing the Nurse Intraoperative Report with the Addendum



Anesthesia Report

If the facility has set the USE ANESTHESIA REPORT parameter to YES, then all Anesthesia Reports require an electronic signature. The following scenario only applies to facilities that use the Anesthesia Report.

Signing the Anesthesia Report

General surgery was performed on Frank Florida. Upon completion of the case, the anesthetist, Debbie Athens, determines that all of the necessary information for the Anesthesia Report has been entered. She then enters the date and time the anesthesia care ended in the ANES CARE END TIME field, which triggers an alert that is sent to the anesthetist responsible for signing the report. (The Anes Care End Time definition may vary according to local anesthesia policy.) Anesthetist Athens, who is responsible for signing the report, receives the alert displayed below.

Example: Viewing the Ready for Signature Alert

```
1.   FLORIDA,FRANK (F3021) MVR (ANES REPORT ready to complete)
          Select from 1 to 1
          or enter ?, A, F, S, P, M, R, or ^ to exit: 1
```

Anesthetist Athens accesses the Anesthesia Report option to electronically sign the report. The *Anesthesia Report* option displays the first page of the Anesthesia Report.

Example: Viewing the First Page of the Anesthesia Report

```
FLORIDA,FRANK (577-78-6565)
    MEDICAL RECORD         ANESTHESIA REPORT - CASE #285                PAGE 1

Operating Room: NOT ENTERED

Anesthetist: ATHENS,DEBBIE             Relief Anesth:
Anesthesiologist:                      Assist Anesth:
Attending Code:

Anes Begin:  JUL 29, 2003  15:09       Anes End:  JUL 29, 2003  16:17

ASA Class:

Operation Disposition:SICU

Anesthesia Technique(s):
GENERAL  (PRINCIPAL)
  Agent:     LIDOCAINE 1% W/EPI INJ 50ML MDV
  Intubated: YES
  Trauma: NONE


Press <return> to continue, 'A' to access Anesthesia Report functions,
or '^' to exit: A
```

Anesthetist Athens notices that the new Anesthesia Report displays key fields on the first page. Several of these fields are required before the Surgery software will allow her to electronically sign the report. If any of these fields are left blank, a warning will display prompting her to provide the missing information. These fields, ANES CARE START TIME, ANES CARE END TIME, ANESTHESIA TECHNIQUE, ASA CLASS, OP DISPOSITION, and PRINC ANESTHETIST, must all be completed before the Anesthesia Report can be electronically signed.

Anesthetist Athens is ready to sign off on the report; however, she does not realize that the ASA CLASS has not been entered. She enters an **A** at the "Press <return> to continue, 'A' to access Anesthesia Report functions or '^' to exit: " prompt at the bottom of the screen. The *Anesthesia Report* functions display.

Example: Using the *Anesthesia Report* Functions

```
 FLORIDA,FRANK (577-78-6565)   Case #285 - JUL 29,2003


 Anesthesia Report Functions:

  1. Edit report information
  2. Print/View report from beginning
  3. Sign the report electronically

Select number: 2// 3
```

Anesthetist Athens selects the *Sign the report electronically* function (#3). Because the ASA CLASS field has not been entered, the following message displays.

Example: Viewing the Missing Field Warning

```
The following information is required before this report may be signed:

     ASA CLASS

Do you want to enter this information? YES// NO
```

Before editing the ASA CLASS field information, Anesthetist Athens decides to print a hard copy of the report to review. After entering **NO** at the "Do you want to enter this information? YES//" prompt, she selects the *Print/View report from beginning* function (#2) and prints out the unsigned report.

Example: Printing the Unsigned Report

```
FLORIDA,FRANK (577-78-6565)   Case #285 - JUL 29,2003

 Anesthesia Report Functions:

  1. Edit report information
  2. Print/View report from beginning
  3. Sign the report electronically

Select number: 2// 2
```

```
---------------------------------------------------------------------------
FLORIDA,FRANK  577-78-6565                                ANESTHESIA REPORT
---------------------------------------------------------------------------
NOTE DATED: 07/31/2003 08:00  ANESTHESIA REPORT

SUBJECT: Case #: 285

Anesthetist: ATHENS,DEBBIE              Relief Anesth:
Anesthesiologist: SALISBURY,DIANE       Assist Anesth:
Attending Code: 3. STAFF ASSISTING C.R.N.A.

Anes Begin:  JUL 29, 2003  15:09        Anes End:  JUL 29, 2003  16:17

ASA Class:

Operation Disposition:SICU

Anesthesia Technique(s):
GENERAL  (PRINCIPAL)
  Agent:     LIDOCAINE 1% W/EPI INJ 50ML MDV

Enter RETURN to continue or '^' to exit:
```

After confirming that the ASA CLASS is the only information that has been omitted, Anesthetist Athens chooses the *Edit report information* function (#1) to update the information, and then makes the correction.

Example: Editing the Anesthesia Report

```
FLORIDA,FRANK (577-78-6565)   Case #285 - JUL 29,2003



 Anesthesia Report Functions:

  1. Edit report information
  2. Print/View report from beginning
  3. Sign the report electronically

Select number: 2// 1
```

```
 ** ANESTHESIA REPORT **   CASE #285     FLORIDA,FRANK PAGE 1 OF 2

1    OPERATING ROOM:      OR1
2    PRINC ANESTHETIST:  ATHENS,DEBBIE
3    RELIEF ANESTHETIST:
4    ANESTHESIOLOGIST SUPVR: SALISBURY,DIANE
5    ANES SUPERVISE CODE: 3. STAFF ASSISTING C.R.N.A.
6    ASST ANESTHETIST:
7    ANES CARE START TIME: JUL 29, 2003  AT 15:09
8    ANES CARE END TIME: JUL 29, 2003  AT 16:17
9    ASA CLASS:
10   OP DISPOSITION:     SICU
11   ANESTHESIA TECHNIQUE: (MULTIPLE)(DATA)
12   PRINCIPAL PROCEDURE: OPEN APPENDECTOMY
13   OTHER PROCEDURES:   (MULTIPLE)(DATA)
14   MEDICATIONS:        (MULTIPLE)
15   MIN INTRAOP TEMPERATURE (C):

Enter Screen Server Function:  9
ASA Class: 1  1     1-NO DISTURB.
```

```
** ANESTHESIA REPORT **   CASE #285     FLORIDA,FRANK PAGE 1 OF 2

1    OPERATING ROOM:     OR1
2    PRINC ANESTHETIST:  ATHENS,DEBBIE
3    RELIEF ANESTHETIST:
4    ANESTHESIOLOGIST SUPVR: SALISBURY,DIANE
5    ANES SUPERVISE CODE: 3. STAFF ASSISTING C.R.N.A.
6    ASST ANESTHETIST:
7    ANES CARE START TIME: JUL 29, 2003  AT 15:09
8    ANES CARE END TIME: JUL 29, 2003  AT 16:17
9    ASA CLASS:          1-NO DISTURB.
10   OP DISPOSITION:     SICU
11   ANESTHESIA TECHNIQUE: (MULTIPLE)(DATA)
12   PRINCIPAL PROCEDURE: OPEN APPENDECTOMY
13   OTHER PROCEDURES:   (MULTIPLE)(DATA)
14   MEDICATIONS:        (MULTIPLE)
15   MIN INTRAOP TEMPERATURE (C):

Enter Screen Server Function: ^
```

If any other information had been incorrect, Anesthetist Athens could use the *Edit report information* function (#1) to edit any of the fields on the Anesthesia Report.

After reviewing her printout, Anesthetist Athens decides that the report is complete and ready for electronic signature. She chooses the *Sign the report electronically* function (#3) and electronically signs the report.

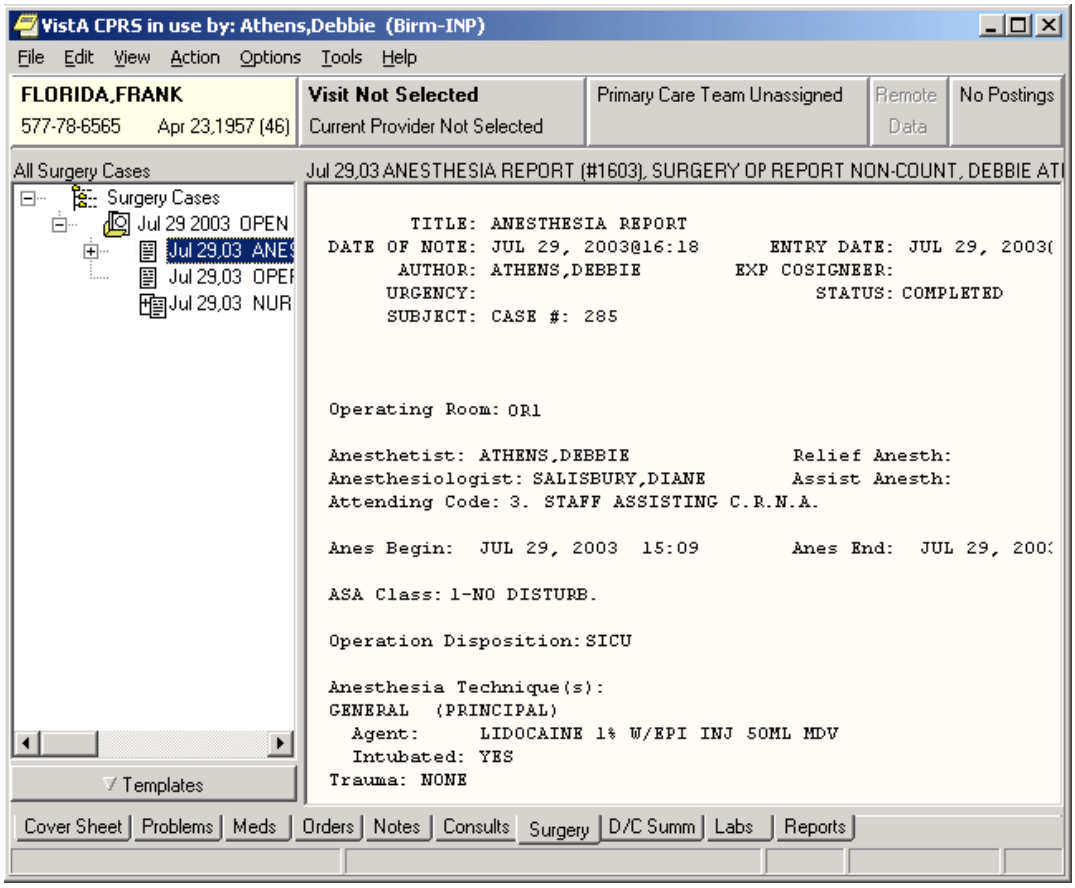
Example: Electronically Signing the Anesthesia Report

```
FLORIDA,FRANK (577-78-6565)   Case #285 - JUL 29,2003


 Anesthesia Report Functions:

  1. Edit report information
  2. Print/View report from beginning
  3. Sign the report electronically

Select number: 2// 3  Sign the report electronically

Enter your Current Signature Code:    SIGNATURE VERIFIED ..

Press RETURN to continue...
```

When typing the electronic signature code, no characters will display on the screen.

Since this report has been signed, it can now be viewed on the CPRS Surgery tab.

Example: Viewing the Anesthesia Report on the CPRS Surgery Tab



Creating an Addendum for the Anesthesia Report

After the Anesthesia Report has been signed, Anesthetist Athens notices that the BLOOD LOSS (ML) field was entered incorrectly. To update the information, she accesses the *Anesthesia for an Operation Menu* option and chooses the *Anesthesia Information (Enter/Edit)* option.

A warning displays, informing her that this report was previously signed.

Example: Viewing a Warning Indicating the Report was Previously Signed

```
                              >>>  WARNING  <<<

   Electronically signed reports are associated with this case.  Editing
   of data that appear on electronically signed reports will require the
   creation of addenda to the signed reports.

Enter RETURN to continue or '^' to exit: <Enter>
```

Anesthetist Athens presses **<Enter>** and proceeds to edit the BLOOD LOSS (ML) field on the Anesthesia Report.

Example: Editing the Anesthesia Report

```
** ANESTHESIA REPORT **   CASE #285  FLORIDA,FRANK  PAGE 2 OF 2

1    MONITORS:           (MULTIPLE)
2    REPLACEMENT FLUID TYPE: (MULTIPLE)
3    BLOOD LOSS (ML): 800 ml
4    TOTAL URINE OUTPUT (ML):
5    PAC(U) ADMIT SCORE:
6    PAC(U) DISCH SCORE:
7    POSTOP ANES NOTE DATE:
8    POSTOP ANES NOTE:   (WORD PROCESSING)
9    INTRAOPERATIVE OCCURRENCES: (MULTIPLE)
10   POSTOP OCCURRENCE:  (MULTIPLE)
11   GENERAL COMMENTS:   (WORD PROCESSING)

Enter Screen Server Function:  3
Intraoperative Blood Loss (ml): 800// 790
```

```
** ANESTHESIA REPORT **   CASE #285  FLORIDA,FRANK  PAGE 2 OF 2

1    MONITORS:           (MULTIPLE)
2    REPLACEMENT FLUID TYPE: (MULTIPLE)
3    BLOOD LOSS (ML):    790 ml
4    TOTAL URINE OUTPUT (ML):
5    PAC(U) ADMIT SCORE:
6    PAC(U) DISCH SCORE:
7    POSTOP ANES NOTE DATE:
8    POSTOP ANES NOTE:   (WORD PROCESSING)
9    INTRAOPERATIVE OCCURRENCES: (MULTIPLE)
10   POSTOP OCCURRENCE:  (MULTIPLE)
11   GENERAL COMMENTS:   (WORD PROCESSING)

Enter Screen Server Function:
```

After completing her edits, a warning displays telling Anesthetist Athens that she must create a signed addendum for the case.

Example: Viewing the Automatic Addendum Warning

```
FLORIDA,FRANK (577-78-6565)   Case #285 - JUL 29,2003

An addendum to each of the following electronically signed document(s) is
required:

          Anesthesia Report - CASE #285

If you choose not to create an addendum, the original data will be restored
to the modified fields appearing on the signed reports.


Create addendum? YES// Y  YES
```

At the "Create addendum? YES//" prompt, Anesthetist Athens types a **Y** and proceeds to create the addendum. The addendum information is presented for her review.

Example: Viewing the Addendum Information

```
Addendum for Case #285 – JUL 29,2003
Patient: FLORIDA,FRANK (577-78-6565)
------------------------------------------------------------------------------

The Intraoperative Blood Loss (ml) field was changed
  from 800
    to 790

Enter RETURN to continue or '^' to exit:  <Enter>
```

After reviewing the automatic addendum for accuracy, Anesthetist Athens presses **<Enter>** and proceeds to electronically sign the addendum to the report. If she had edited information on the report by mistake, she could decline to sign the addendum and the information for that field would revert back to what was previously entered**.** Prior to the signature prompt, she is given the opportunity to provide additional comments regarding the addendum. Anesthetist Athens types in a comment and then electronically signs the addendum.

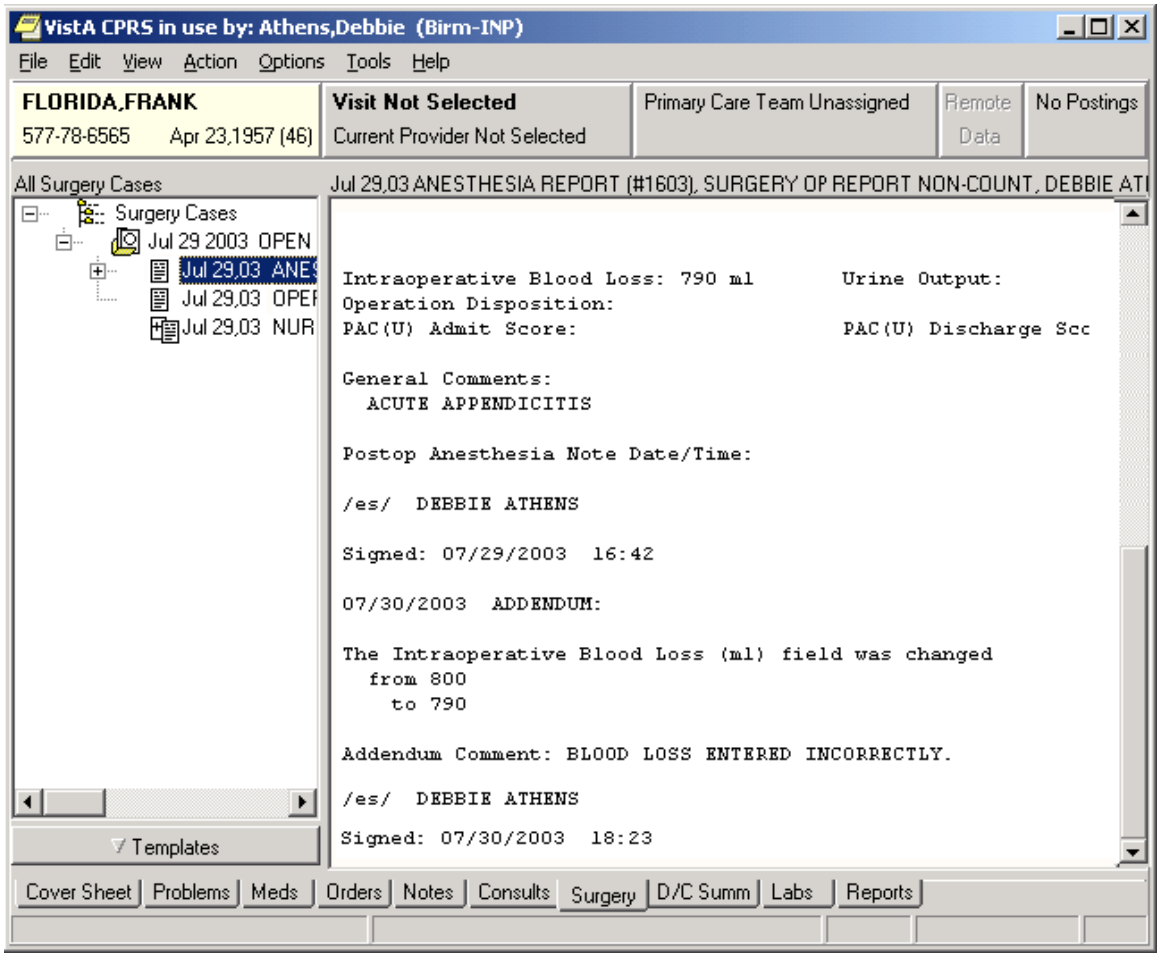
Example: Adding A Comment to the Anesthesia Report

```
FLORIDA,FRANK (577-78-6565)   Case #285 - JUL 29,2003
Patient: FLORIDA,FRANK (577-78-6565)
------------------------------------------------------------------------------

The Intraoperative Blood Loss (ml) field was changed
  from 800
    to 790

Addendum Comment: BLOOD LOSS ENTERED INCORRECTLY.

Enter RETURN to continue or '^' to exit: <Enter>

Enter your Current Signature Code:    SIGNATURE VERIFIED..

Press RETURN to continue...
```

When typing the electronic signature code, no characters will display on the screen.

Following the electronic signature of the addendum, the report displays on the CPRS Surgery tab.

Example: Viewing the Anesthesia Report with Addendum on the CPRS Surgery Tab



Procedure Report (Non-O.R.)

The following scenarios demonstrate how to use both CPRS and the List Manager options to electronically sign the Procedure Report (Non-O.R.). Each scenario includes text and screen captures to aid the user in understanding the Electronic Signature process.

The first scenario provides instructions and screen captures related to viewing, editing, and electronically signing the Procedure Report (Non-O.R.) using CPRS.

The second scenario demonstrates how the List Manager options can also be used to view, edit, and electronically sign the Procedure Report (Non-O.R.).

If the Procedure Report (Non-O.R.) option within the Surgery software is used to display the report, one of the four following scenarios occurs:

- If the Procedure Summary has been signed, the signed procedure summary will be preceded with the statement, “The following procedure summary has been electronically signed.”

- If the procedure summary has not been signed, the following statement displays: “A Procedure Report (Non-OR) is not available.”

- If the DICTATED SUMMARY EXPECTED field is set to not include a summary, the following statement displays: “A Non-O.R. Procedure Summary will not be created for this procedure.”

(This page included for two-sided copying.)

Scenario 1: Using CPRS Options

The following scenario uses CPRS options to demonstrate different methods of viewing, signing, and editing a Procedure Report (Non-O.R.).

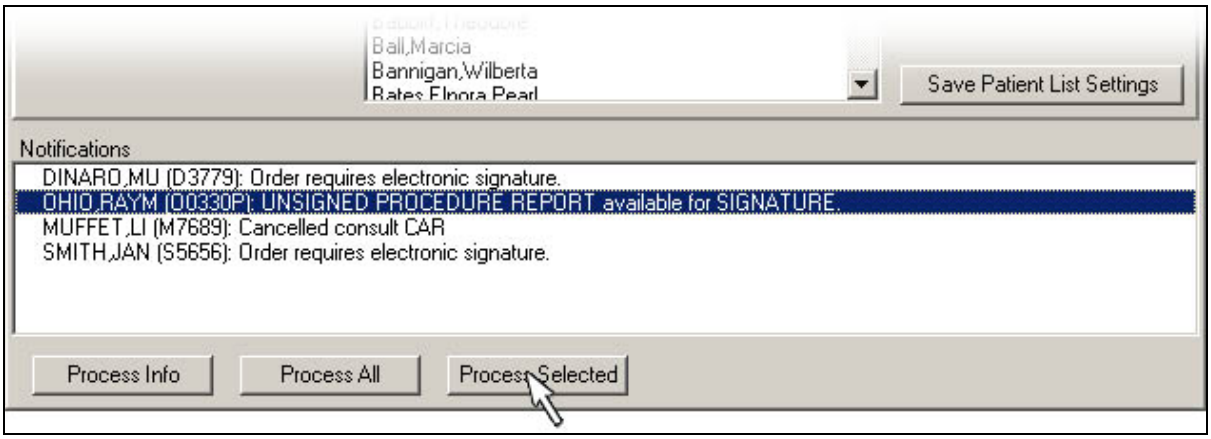
Signing the Procedure Report (Non-O.R.)

A procedure was performed on Raymond Ohio. Upon completion of the case, the new DICTATED SUMMARY EXPECTED field was updated to **YES**, and the date and time the procedure was completed was entered in the TIME PROCEDURE ENDED field. Dr. Jack Springfield then dictates his Procedure Summary. After the report is transcribed, it is uploaded into TIU and an alert is sent to Dr. Springfield notifying him that his Procedure Summary is ready for signature.

If the DICTATED SUMMARY EXPECTED field was not entered or set to NO, the Procedure Summary would not be created and no further action would be necessary.

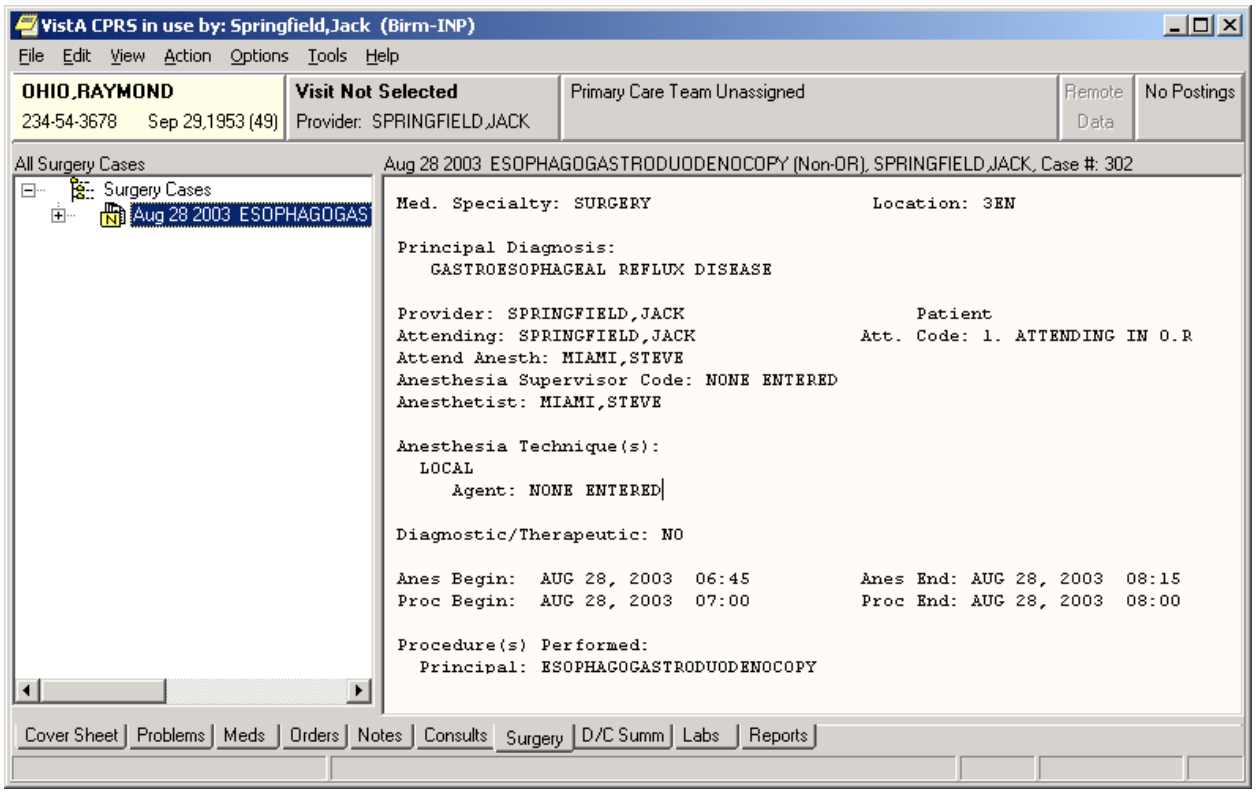
If the DICTATED SUMMARY EXPECTED field is initially set to NO, but the user later decides a Procedure Report (Non-O.R.) is needed, then the following procedure should be completed. First, the user should edit the Non-O.R. procedure in the Surgery software, and set the DICTATED SUMMARY EXPECTED field to "Yes." Then, the user should re-enter the TIME PROCEDURE ENDED field. This will create the Non-OR stub in TIU.

Example: Viewing the Ready for Signature Alert



By responding to the alert, Dr. Springfield automatically accesses the CPRS Surgery tab. The Surgery tab opens with the case selected and the report open.

Example: Responding to the Alert Sends Dr. Springfield to the Surgery Tab

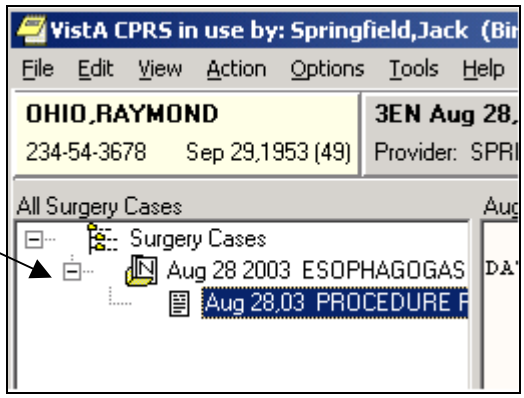


Dr. Springfield reviews the information on the report and notices that the transcribed summary contains an error.

By accessing the *Edit Report* option from the *Action* menu (or by right-clicking in the document pane), he proceeds to edit the transcribed Procedure Report (Non-O.R.).

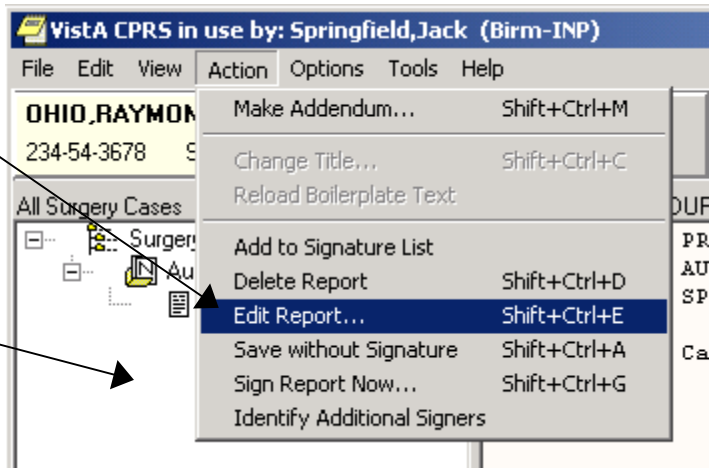
Example: Using the *Edit Report* Option from the *Action* Menu to Edit the Report

First, Dr. Springfield selects the report by clicking on the plus icon (it will list the reports under the surgery case and change to a minus), and then clicking on the report.



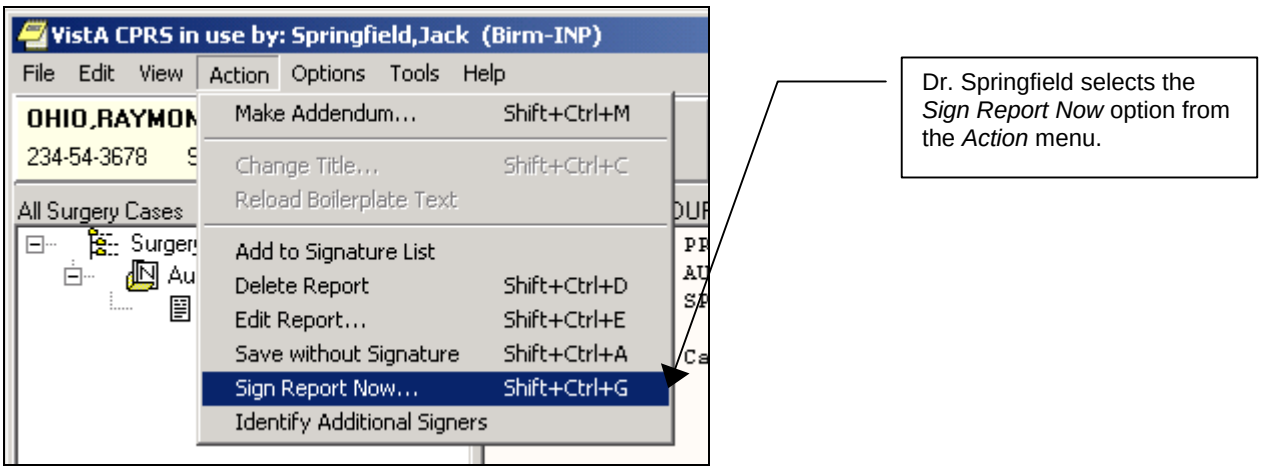
Then, he selects the *Edit Report* option from the *Action* menu.

Dr. Springfield can also use these same menu options by right-clicking in the document pane.



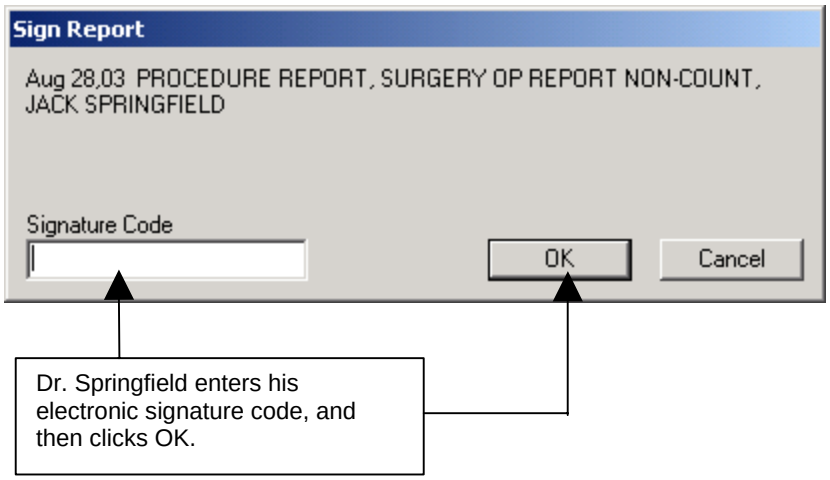
Dr. Springfield reviews the edited unsigned Procedure Summary and decides that it is correct and ready for electronic signature. Using the *Sign Report Now* option from the *Action* menu (or by right-clicking in the document pane), he electronically signs the report.

Example: Using the *Sign Report Now* option



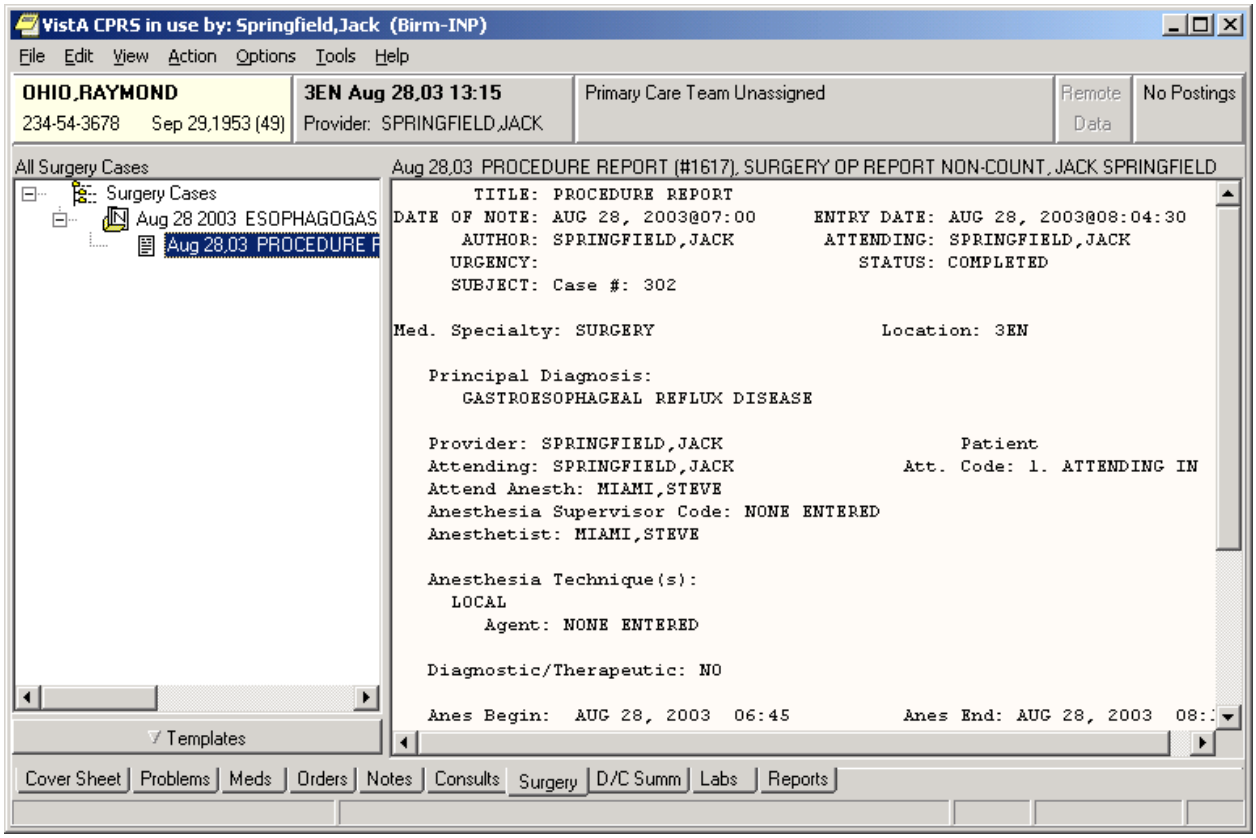
Next, Dr. Springfield is prompted to enter his electronic signature code.

Example: Entering an Electronic Signature Code



After the report is signed, it is viewable to others within the Surgery tab in CPRS, based on the business rules defined at the facility.

Example: Viewing the Procedure Report (Non-O.R.) on the CPRS Surgery Tab



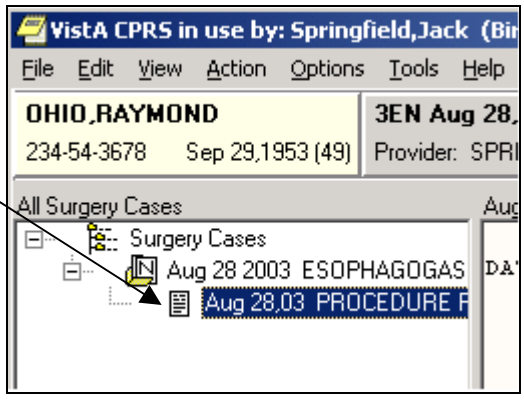
(This page included for two-sided copying.)

Creating an Addendum for the Procedure Report (Non-O.R.)

After studying the summary, Dr. Springfield realizes he made an error in the procedure start time and needs to correct it. Because the Procedure Report (Non-O.R.) has already been signed, he must create an addendum to the report. Dr. Springfield creates the addendum using the *Make Addendum* option from the *Action* menu (or by right-clicking in the document pane).

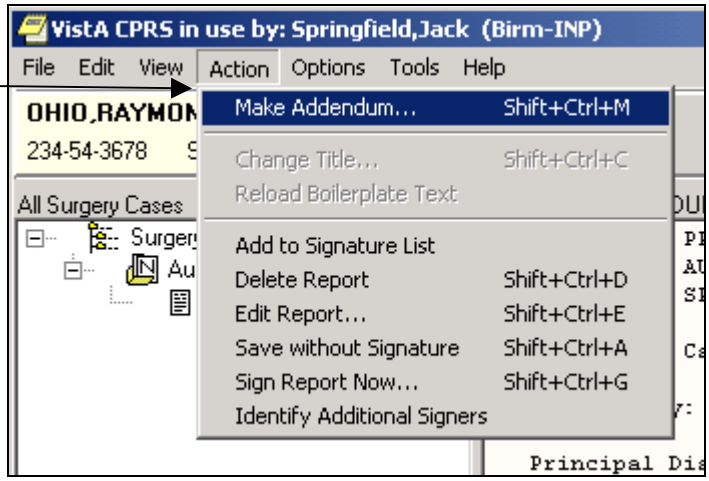
Example: Selecting the Report

Dr. Springfield first selects the report that requires an addendum.



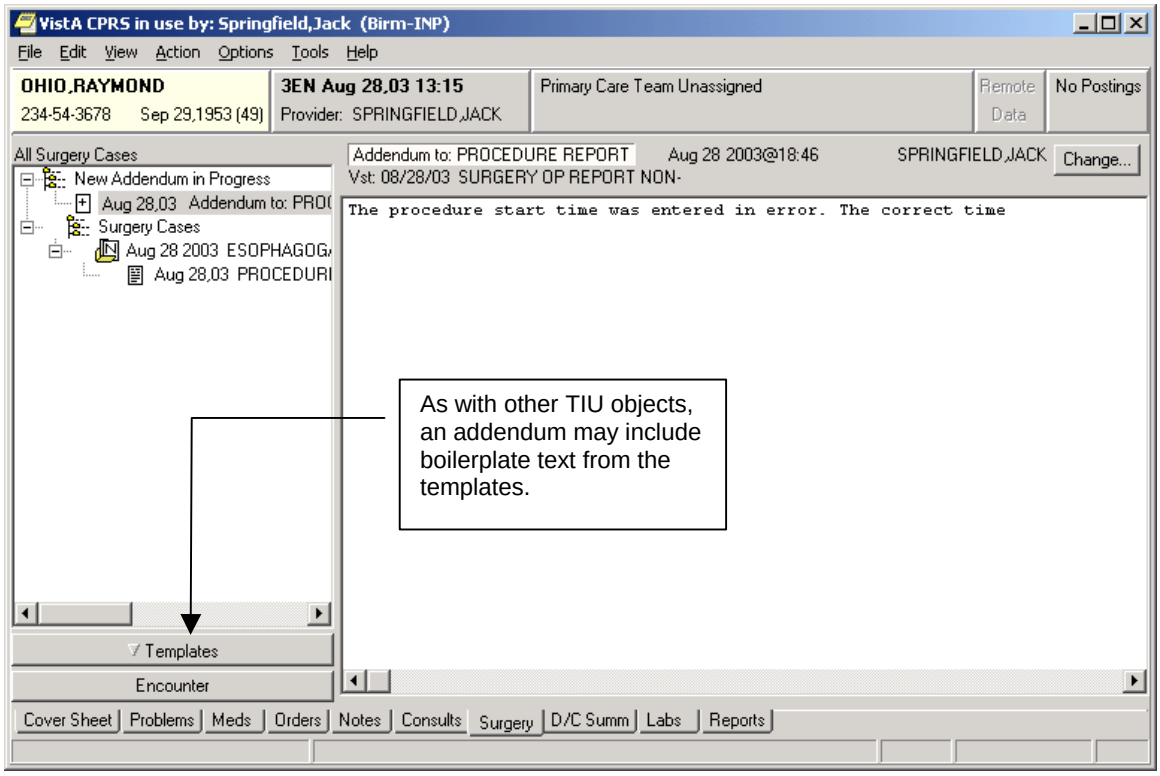
Example: Selecting the *Make Addendum* Option

He then selects the *Action* menu, and chooses the *Make Addendum* option.



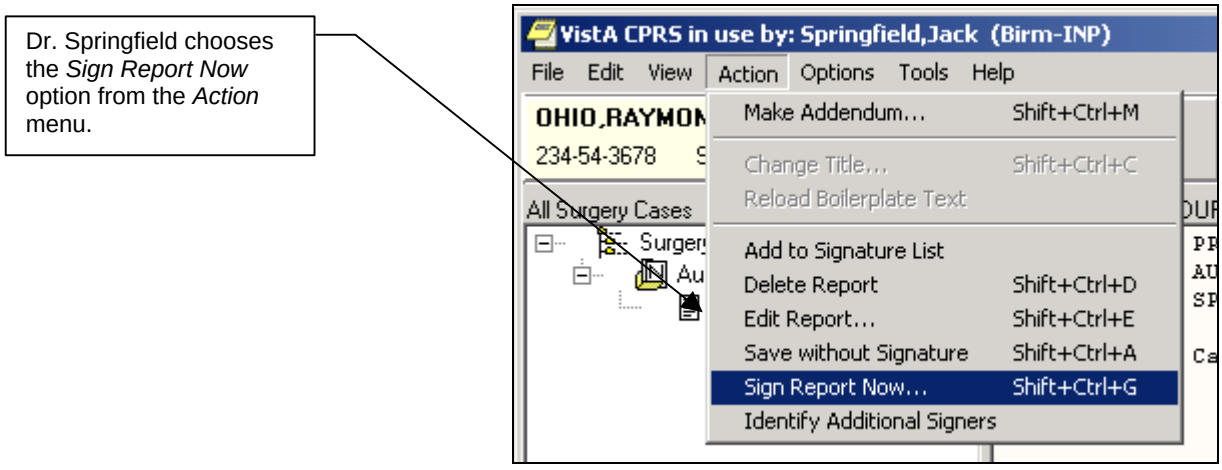
Dr. Springfield edits the text of his summary. The date and time of the addendum is automatically stored when the addendum is saved.

Example: Typing the Addendum



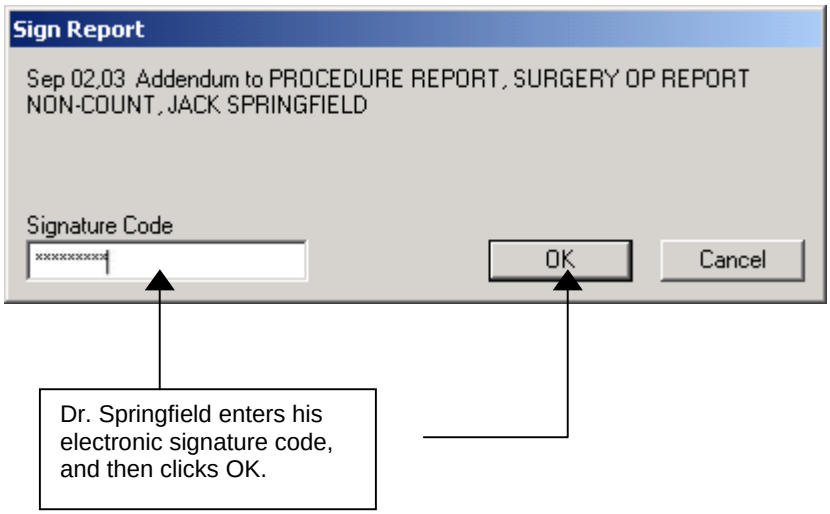
After Dr. Springfield has completed the editing, he saves the report using the *Sign Report Now* option. This option is also available by right-clicking in the document pane.

Example: Saving the Addendum



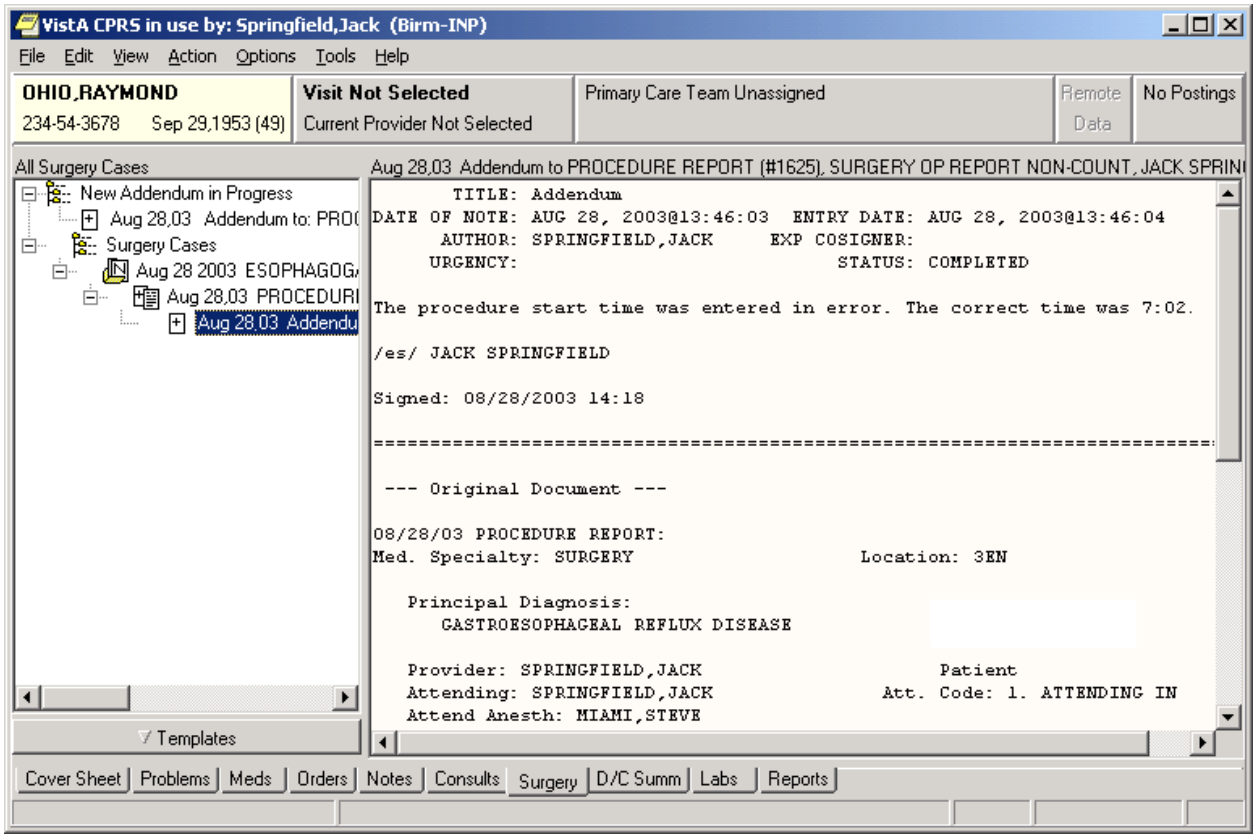
He is then prompted to sign the addendum. Dr. Springfield enters his electronic signature code.

Example: Entering the Electronic Signature Code



A signed addendum displays when a user views or prints the Procedure Report (Non-O.R.).

Example: Viewing the Procedure Report (Non-O.R.) with an Addendum



Scenario 2: Using List Manager Options

The following scenario uses the List Manager options to demonstrate different methods of viewing, signing, and editing the Procedure Summary.

Signing the Procedure Report (Non-O.R.)

Using the List Manager options to edit, sign, and add addenda to the Procedure Report (Non-O.R.) is similar to the process used in Scenario 1 of this section. The process begins when Dr. Springfield receives an alert.

Example: Viewing the Ready for Signature Alert

```
1.   OHIO,R (F6572): UNSIGNED NON-O.R. REPORT available for SIGNATURE.
2.   IOWA,L (M7689): Cancelled consult CAR
3.   NEVADA,N (S5656): Order requires electronic signature.
          Select from 1 to 3
          or enter ?, A, F, S, P, M, R, or ^ to exit: 1

OHIO,RAYMOND       9-29-53    234543678     YES     SC VETERAN
            (26 notes)  C: 09/15/99 09:24  (amended 10/01/99 08:37)
            (1 note )  W: 02/21/97 09:19
            (9 notes)  D: 06/14/99 13:32
                       A: Known allergies
 Enrollment Priority: GROUP 1    Category: IN PROCESS    End Date:


Opening PROCEDURE NON-O.R. REPORT record for review...
```

Dr. Springfield then edits the Procedure Report (Non-O.R.) by accessing the *TIU List Manager* options.

Example: Editing the Procedure Report (Non-O.R.)

```
Browse Document               Aug 28, 2003 15:53:20          Page:    1 of    4
                               PROCEDURE NON-O.R. REPORT
OHIO,RAYMOND        234-54-3678   2B MED            Adm: 08/28/2003  Dis:          _

SURGICAL CASE #: 1
_____________________________________________________________________________
Preoperative  Diagnosis:
  Primary: BPH                                ICD9 Code: 530.7
_____________________________________________________________________________
       Surgeon: SPRINGFIELD,JACK    Surgical Priority: URGENT
Attend Surgeon: SPRINGFIELD,JACK          Attend Code: NOT ENTERED
 1st Assistant: TULSA,LARRY
        2nd Assistant: RICHMOND,CHARLES

Other Scrubbed Assistants: NONE ENTERED
_____________________________________________________________________________
Anesthetist: MIAMI,STEVE      Asst Anesthetist: N/A
Attending Anesthesiologist: LANSING,EMILY
+         + Next Screen  - Prev Screen  ?? More actions                  >>>

       Find                     Sign/Cosign              Link ...
       Print                    Copy                     Encounter Edit
       Edit                     Identify Signers         Interdiscipl'ry Note
       Make Addendum            Delete                   Quit
Select Action: Next Screen// ED  Edit
```

```
HOSPITAL LOCATION: 3 EN//
DATE/TIME OF NOTE: AUG 28,2003@14:57//
AUTHOR OF NOTE: SPRINGFIELD,JACK//
SUBJECT (OPTIONAL description): TEST//

Calling text editor, please wait...
```

```
==[ WRAP ]==[ INSERT ]=======< Patient: OHIO,RAYMOND >=====[ <PF1>H=Help ]====
NOTE DATE: 08/28/2003  UROLOGY DIAGNOSTICS
VISIT: 08/28/2003 14:00 BO UROLOGY DX PROCEDURE 3804
                     (Place an X in appropriate box)
Indications: This is a 73-year-old white male with a history of
gastroesophageal reflux disease, and rule out Barrett's esophagus.


Renal US(10/30/2002)-negative
UA(10/01) 1-3 RBC
Urine cx(10/01)-negative
psa(10/01) 2.5

[] hematuria         [] r/o bladder tumor  [] r/o prostate tumor
[] upper tract       [] hesitancy          [] weak stream
[] straining to void [] intermittency      [] frequency
[] nocturia          [] urgency            [] incontinence
[] retention         [] incomplete voiding [] post-void dribbling

Anesthesia:
<=======T=======T=======T=======T=======T=======T=======T=======T=======T>======
```

After determining that the report is correct, Dr. Springfield electronically signs the report.

Example: Electronically Signing the Procedure Report (Non-O.R.)

```
Enter your Current Signature Code:       SIGNATURE VERIFIED..
Print this note? No// Y  YES
DEVICE: HOME// SURG HP LJ 8100

Continue (Y/N) or (F)orward or (R)enew YES// <Enter>

 1.   KANSAS,T (M7689): Cancelled consult CAR
 2.   ARIZONA,A (S5656): Order requires electronic signature.
          Select from 1 to 2
          or enter ?, A, F, S, P, M, R, or ^ to exit: <Enter>

   OE     CPRS Clinician Menu
   RR     Results Reporting Menu
   AD     Add New Orders
   RO     Act On Existing Orders
   PP     Personal Preferences ...


You have PENDING ALERTS
          Enter  "VA   VIEW ALERTS     to review alerts

Select Clinician Menu Option:
```

When typing the electronic signature code, no characters will display on the screen.

(This page included for two-sided copying.)

Creating an Addendum for the Procedure Report (Non-O.R.)

Dr. Springfield accesses the TIU List Manager options and selects the appropriate case. Four different instances would indicate that the report had already been signed.

- The document status is complete.
- The document is in the "All signed notes" list.
- The document is not in the "All unsigned notes" list.
- If a user tries to change a signed report, the changes can be made, but the edit will require a signed addendum. The ability to create addenda also may be limited by local business rules.

Most addenda are added using CPRS. In List Manager mode, an addendum can be added using either the *Individual Patient Document* option or the *Multiple Patient Documents* option within the TIU List Manager. Earlier in this manual, an example of how to use the CPRS GUI and the List Manager *Multiple Patient Documents* option were provided. Following is an example demonstrating how to use the *Individual Patient Document* option.

Example: Using the *Individual Patient Document* Option

```
Select Progress Notes/Discharge Summary [TIU] Option: ?

   1      Progress Notes User Menu ...
   2      Discharge Summary User Menu ...
   3      Integrated Document Management ...
   4      Personal Preferences ...

Enter ?? for more options, ??? for brief descriptions, ?OPTION for help text.

Select Progress Notes/Discharge Summary [TIU] Option: INtegrated Document Manage
ment

                           --- Clinician's Menu ---

Select Integrated Document Management Option: ?

   1      Individual Patient Document
   2      All MY UNDICTATED Documents
   3      All MY UNSIGNED Documents
   4      Multiple Patient Documents
   5      Enter/edit Document

Enter ?? for more options, ??? for brief descriptions, ?OPTION for help text.

Select Integrated Document Management Option: INdividual Patient Document
Select PATIENT NAME: OHIO,RAYMOND  OHIO,RAYMOND        8-29-53         234543678P
     YES     SC VETERAN
            (1 note )   D: 08/28/03 16:38  (addendum 08/28/03 16:38)

Available documents:  08/11/2003 thru 08/28/2003  (2)

Please specify a date range from which to select documents:
List documents Beginning: 08/11/2003// <Enter>  (AUG 11, 2003)
                  Thru: 08/28/2003// <Enter>  (AUG 28, 2003)
```

```
Select Progress Notes/Discharge Summary [TIU] Option: ?

   1      Progress Notes User Menu ...
   2      Discharge Summary User Menu ...
   3      Integrated Document Management ...
   4      Personal Preferences ...

Enter ?? for more options, ??? for brief descriptions, ?OPTION for help text.

Select Progress Notes/Discharge Summary [TIU] Option: INtegrated Document Manage
ment

                          --- Clinician's Menu ---

Select Integrated Document Management Option: ?

   1      Individual Patient Document
   2      All MY UNDICTATED Documents
   3      All MY UNSIGNED Documents
   4      Multiple Patient Documents
   5      Enter/edit Document

Enter ?? for more options, ??? for brief descriptions, ?OPTION for help text.
                     Visit: 08/28/2003
Opening PROCEDURE REPORT record for review...
                             Aug 28, 2003@11:47:48

Select Integrated Document Management Option: INdividual Patient Document
Select PATIENT NAME: OHIO,RAYMOND  OHIO,RAYMOND        8-29-53         234543678P
     YES     SC VETERAN
            (1 note )   D: 08/28/03 16:38  (addendum 08/28/03 16:38)

Available documents:  08/11/2003 thru 08/28/2003  (2)

Please specify a date range from which to select documents:
List documents Beginning: 08/11/2003// <Enter>  (AUG 11, 2003)
                  Thru: 08/28/2003// <Enter>  (AUG 28, 2003)
```

Now, the *Make Addendum* action can be used.

```
Adding ADDENDUM
DATE/TIME OF NOTE: 08/28/03@17:51// <Enter>
AUTHOR OF NOTE: SPRINGFIELD,JACK// <Enter> SALT LAKE CITY     UTAH     TB     123
4     PHYSICIAN

Calling text editor, please wait...
==[ WRAP ]==[ INSERT ]=======< Patient: FLORIDA,FRANK >======[ <PF1>H=Help ]===
The time the operation began was entered in error in the Operation Report. The correct time was
7:45 am.




<=======T=======T=======T=======T=======T=======T=======T=======T=======T>=====

Saving Addendum with changes...


Enter your Current Signature Code:    SIGNATURE VERIFIED..
Print this note? No//   NO

Opening PROCEDURE REPORT record for review...
```

When Dr. Springfield types the electronic signature code, no characters display on the screen.

```
Browse Document                Aug 28, 2003 17:57:20          Page:    1 of    6
                                PROCEDURE REPORT
OHIO,R         234-34-3678P                       Visit Date: 08/28/2003 16:48
                                                                               .
Med. Specialty: SURGERY                  Location: SURGICAL CLINIC

Principal Diagnosis:
  Primary: GRE                                ICD9 Code: 530.7

Provider: SPRINGFIELD,JACK                       Patient Status: OUTPATIENT
Attending: SPRINGFIELD,JACK             Att Code: 1. STAFF
Attend Anesth: N/A
Anesthesia Supervisor Code: 1. STAFF CASE
Anesthetist: MIAMI, STEVE

Anesthesia Technique(s):
  LOCAL
     Agent: NONE ENTERED
+         + Next Screen  - Prev Screen  ?? More actions
     Find                      Sign/Cosign               Link ...
     Print                     Copy                      Encounter Edit
     Edit                      Identify Signers          Interdiscipl'ry Note
     Make Addendum             Delete                    Quit
Select Action: Next Screen//
```

The addendum was added, but is not viewable to Dr. Springfield. TIU has added the addendum to the end of the case. He can use one or more of the following commands to scroll the screen to see the attached addendum.

Example: Viewing the Addendum

```
The following actions are also available:
+    Next screen          DN   Down a Line          >    Shift View to Right
-    Previous Screen      GO   Go to Page           <    Shift View to Left
FS   First Screen         RD   Re Display Screen    DD   Detailed Display
LS   Last Screen          ADPL Auto Display(On/Off) CT   Change Title
UP   Up a Line            Q    Quit                 CWAD CWAD Display
```

```
Select Action: Next Screen// GO   GO

Go to Page (1-9): 6
```

```
Browse Document                Aug 28, 2003 17:59:20          Page:    6 of    6
                                PROCEDURE REPORT
OHIO,R         234-34-3678P                       Visit Date: 08/28/2003 16:48
                                                                               .
08/28/2003 ADDENDUM:
The time operation began was entered in error in the Operation Report.
The correct time was 7:45 am.

/es/ JACK SPRINGFIELD

Signed: 08/28/2003 17:59

         + Next Screen  - Prev Screen  ?? More actions
     Find                      Sign/Cosign               Link ...
     Print                     Copy                      Encounter Edit
     Edit                      Identify Signers          Interdiscipl'ry Note
     Make Addendum             Delete                    Quit
Select Action: Quit//
```

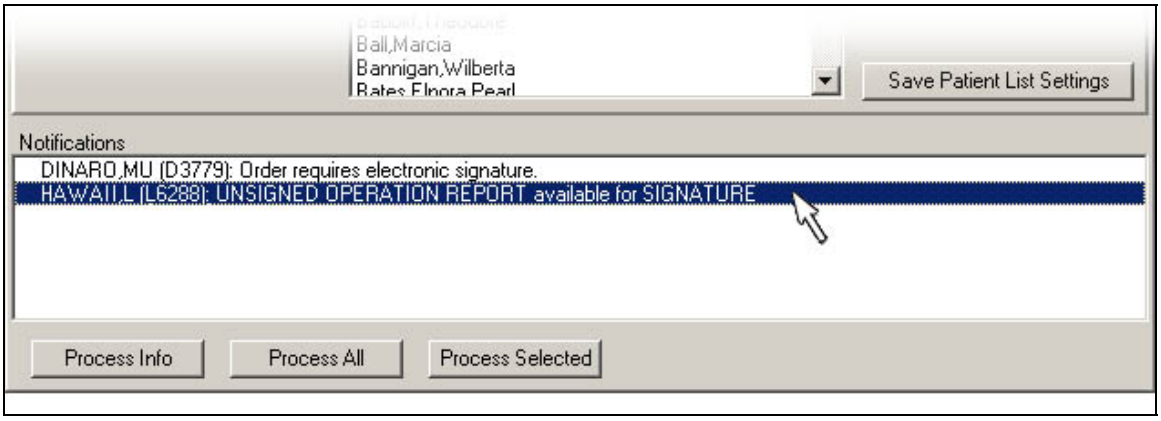
(This page included for two-sided copying.)

Concurrent Operation Report

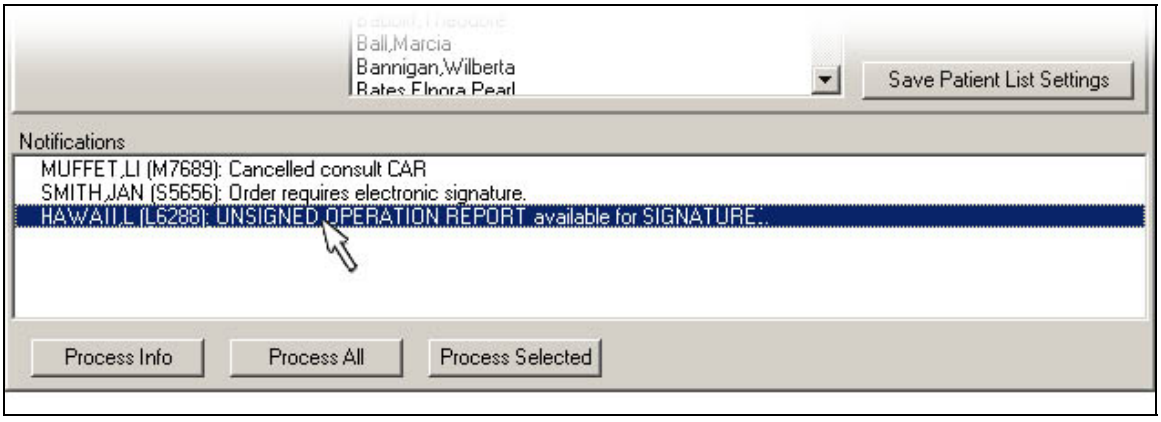
A concurrent case occurs when two or more procedures are performed by two or more specialties on a patient during a single trip to the O.R. The process for signing a concurrent case will not differ from the process for signing a non-concurrent case summary.

Dr. Steve Miami performed cardiac surgery on Lou Hawaii. Concurrently, Dr. Patricia Trenton performed an orthopedic procedure. Upon completion of the cases, both doctors dictate their operative summaries. After the reports are transcribed, both Dr. Miami and Dr. Trenton receive separate alerts that their reports are ready for electronic signature.

Example: Viewing Dr. Miami's Ready for Signature Alert in CPRS



Example: Viewing Dr. Trenton's Ready for Signature Alert in CPRS



From now on, the concurrent cases are handled in exactly the same way as the non-concurrent cases explained earlier.

(This page included for two-sided copying.)

Concurrent Nurse Intraoperative Report

A concurrent case occurs when two or more procedures are performed by two or more specialties on a patient during a single trip to the O.R. The process for signing a concurrent case will not differ from the process for signing a non-concurrent case summary.

Cardiac surgery was performed on Lou Hawaii. Concurrently, a vascular procedure was performed. Nurse Lansing was the circulating nurse assigned to the cardiac case. Nurse Montpelier was the circulating nurse assigned to the vascular case.

Upon completion of the cases, Nurse Lansing enters the time that the patient left the operating room into the TIME PAT OUT OR field, which triggers separate alerts that are sent to each of the two circulating nurses.

Nurse Lansing is notified that the Nurse Intraoperative Report for the cardiac procedure is ready for signature. Nurse Montpelier is notified that the Nurse Intraoperative Report for the vascular procedure is ready for signature. The alerts (from the Surgery package) are displayed below.

Example: Viewing Nurse Lansing's Ready for Signature Alert

```
1.   Case #202 - Nurse Intraoperative Report is ready for signature.
          Select from 1 to 1
          or enter ?, A, F, S, P, M, R, or ^ to exit: 1
```

Example: Viewing Nurse Montpelier's Ready for Signature Alert

```
1.   Case #203 - Nurse Intraoperative Report is ready for signature.
          Select from 1 to 1
          or enter ?, A, F, S, P, M, R, or ^ to exit: 1
```

Nurse Lansing accesses the *Nurse Intraoperative Report* option to electronically sign the cardiac report. The option displays the first page of the Nurse Intraoperative Report.

Example: Viewing the First Page of the Nurse Intraoperative Report

```
MEDICAL RECORD       NURSE INTRAOPERATIVE REPORT - CASE #202          PAGE 1

Operating Room:  OR1-PH                 Surgical Priority: EMERGENCY

Patient in Hold: JAN 14, 2002  07:00    Patient in OR:  JAN 14, 2002  07:30
Operation Begin: JAN 14, 2002  07:45    Operation End:  JAN 14, 2002  08:45
Surgeon in OR:   NOT ENTERED            Patient Out OR: JAN 14, 2002  09:00

Major Operations Performed:
Primary: AORTA CORONARY BYPASS GRAFT

Wound Classification: CLEAN
Operation Disposition: WARD
Discharged Via: STRETCHER

Surgeon: SPRINGFIELD,JACK              First Assist: MONTANA,JOHNNY
Attend Surg: SPRINGFIELD,JACK          Second Assist: N/A
Anesthetist: HELENA,LAURIE             Assistant Anesth: N/A

 Press <return> to continue, 'A' to access Nurse Intraoperative Report
 functions, or '^' to exit:
```

At the "Press <return> to continue, 'A' to access Nurse Intraoperative Report functions, or '^' to exit:" prompt, Nurse Lansing types **A** to access the *Nurse Intraoperative Report* functions.

Example: Using the *Nurse Intraoperative Report* Functions

```
 Nurse Intraoperative Report Functions:

  1. Edit report information
  2. Print/View report from beginning
  3. Sign the report electronically

Select number: 2//  1   Edit report information
```

Remembering that the Major or Minor field information was not correct, Nurse Lansing selects the *Edit report information* function (#1) to update the information. Since neither Nurse Lansing nor Nurse Montpelier has signed their reports, Nurse Lansing can update one or both reports without creating an addendum.

Also, since both cases were major procedures, Nurse Lansing chooses to make the change on both cases. When editing this information, the "Do you want to store this information in the concurrent case? YES//" prompt displays. She answers **YES**.

Example: Editing the Nurse Intraoperative Report

```
Enter Screen Server Function:  6
Major or Minor: MINOR// MAJOR  MAJOR

Do you want to store this information in the concurrent case ?  YES//  YES
```

After reviewing her edited data in the Nurse Intraoperative Report, Nurse Lansing decides that the report is complete and ready for signature. She chooses the *Sign the report electronically* function (#3) and electronically signs the report.

Example: Electronically Signing the Nurse Intraoperative Report

```
HAWAII,LOU (502-12-1148)   Case #202 - JAN 18, 2002

 Nurse Intraoperative Report Functions:

  1. Edit report information
  2. Print/View report from beginning
  3. Sign the report electronically

Select number: 2// 3  Sign the report electronically

Enter your Current Signature Code:    SIGNATURE VERIFIED..

Press RETURN to continue...
```

At this point, only the Nurse Intraoperative Report for the cardiac case has been signed. Nurse Montpelier must sign the Nurse Intraoperative Report for the vascular case independently.

Since the Nurse Intraoperative Report for the cardiac case has been signed, it is now viewable on the CPRS Surgery tab. The Nurse Intraoperative Report for the vascular case is not yet viewable on the Surgery tab because it has not yet been electronically signed.

Nurse Montpelier receives the alert that the Nurse Intraoperative Report for the vascular case is ready for signature. She acts on the alert and accesses the *Nurse Intraoperative Report* option to electronically sign her report. Prior to signing the report, she notices the OP DISPOSITION field was not entered.

At the prompt, "Press <return> to continue, 'A' to access Nurse Intraoperative Report functions, or '^' to exit: ", she types **A** to access the *Nurse Intraoperative Report* functions.

Example: Using the *Nurse Intraoperative Report* Functions

```
   HAWAII,LOU (502-12-1148P)   Case #203 - JAN 18, 2002

 * * The Nurse Intraoperative Report has been electronically signed. * *

 Nurse Intraoperative Report Functions:

  1. Edit report information
  2. Print/View report from beginning

Select number: 2// 1
```

Nurse Montpelier chooses the *Edit report information* function (#1) to update the OP DISPOSITION field. Because Nurse Lansing has already signed the concurrent case, Nurse Montpelier is warned that edits may impact an already signed report.

Example: Viewing the Automatic Addendum Warning

```
HAWAII,LOU (502-12-1148P)   Case #203 - JAN 18,2002


                              >>>  WARNING  <<<

   Electronically signed reports are associated with this case.  Editing
   of data that appear on electronically signed reports will require the
   creation of addenda to the signed reports.


Enter RETURN to continue or '^' to exit: <Enter>
```

She presses **<Enter>** to edit the report, and the Enter/Edit screen displays. Nurse Montpelier types in her correction and enters **YES** at the "Do you want to store this information in the concurrent case? YES// " prompt.

Example: Editing the Nurse Intraoperative Report

```
** NURSE INTRAOP **   CASE #203  HAWAII,LOU    PAGE 1 OF 5

1    SPONGE COUNT CORRECT (Y/N):
2    SHARPS COUNT CORRECT (Y/N):
3    INSTRUMENT COUNT CORRECT (Y/N):
4    SPONGE, SHARPS, & INST COUNTER:
5    COUNT VERIFIER:
6    TIME PAT IN HOLD AREA:
7    MARKED SITE CONFIRMED: YES
8    PREOPERATIVE IMAGING CONFIRMED: YES
9    TIME OUT VERIFIED:  YES
10   CORRECT SURGERY COMMENTS: (WORD PROCESSING)
11   TIME OPERATION BEGAN:
12   TIME OPERATION ENDS:
13   SURG PRESENT TIME:
14   TIME PAT OUT OR:      JAN 18, 2002 AT 09:00
15   TIME PAT IN OR:       JAN 18, 2002 AT 07:00

Enter Screen Server Function:  <Enter>
```

```
** NURSE INTRAOP **   CASE #203  HAWAII,LOU    PAGE 1 OF 5

1    PRINCIPAL PROCEDURE:  REPAIR TORN ACL, RIGHT KNEE
2    OTHER PROCEDURES:     (MULTIPLE)
3    WOUND CLASSIFICATION:
4    OP DISPOSITION:
5    MAJOR/MINOR:
6    OPERATING ROOM:
7    CASE SCHEDULE TYPE:
8    SURGEON:            SPRINGFIELD,JACK
9    ATTEND SURG:        SPRINGFIELD,JACK
10   FIRST ASST:         MONTANA,JOHNNY
11   SECOND ASST:
12   PRINC ANESTHETIST:  HELENA,LAURIE
13   ASST ANESTHETIST:
14   OTHER SCRUBBED ASSISTANTS: (MULTIPLE)
15   OR SCRUB SUPPORT:   (MULTIPLE)

Enter Screen Server Function:  4
Postoperative Disposition: WARD         W

Do you want to store this information in the concurrent case ?  YES//  Y
```

```
** NURSE INTRAOP **   CASE #203  HAWAII,LOU    PAGE 2 OF 5

1    PRINCIPAL PROCEDURE:  REPAIR TORN ACL, RIGHT KNEE
2    OTHER PROCEDURES:     (MULTIPLE)
3    WOUND CLASSIFICATION:
4    OP DISPOSITION:       WARD
5    MAJOR/MINOR:
6    OPERATING ROOM:
7    CASE SCHEDULE TYPE:
8    SURGEON:            SPRINGFIELD,JACK
9    ATTEND SURG:        SPRINGFIELD,JACK
10   FIRST ASST:         MONTANA,JOHNNY
11   SECOND ASST:
12   PRINC ANESTHETIST:  HELENA,LAURIE
13   ASST ANESTHETIST:
14   OTHER SCRUBBED ASSISTANTS: (MULTIPLE)
15   OR SCRUB SUPPORT:   (MULTIPLE)

Enter Screen Server Function:  ^
```

After entering the OP DISPOSITION field information, Nurse Montpelier types an ^ at the "Enter Screen Server Function:" prompt.

Example: Updating the Concurrent Case

```
The information to be duplicated in the concurrent case will now be entered....


Press RETURN to continue <Enter>
```

Because Nurse Lansing has already electronically signed the cardiac case and Nurse Montpelier responded **YES** to the "Do you want to store this information in the concurrent case? YES// " prompt, Nurse Montpelier cannot edit information on the Nurse Intraoperative Report for the cardiac case without creating an addendum.

Example: Viewing the Automatic Addendum Warning

```
HAWAII,LOU (502-12-1148P)   Case #203 - JAN 18,2002

An addendum to each of the following electronically signed document(s) is
required:

          Nurse Intraoperative Report - Concurrent Case #202

If you choose not to create an addendum, the original data will be restored
to the modified fields appearing on the signed reports.


Create addendum? YES// Y
```

The computer-generated addendum is displayed for Nurse Montpelier to review.

Example: Viewing the Computer-Generated Addendum

```
Addendum for Case #203 - JAN 18,2002
Patient: HAWAII,LOU (502-12-1148P)
------------------------------------------------------------------------------

The Postoperative Disposition field was changed
  from <NOT ENTERED>
    to WARD

Enter RETURN to continue or '^' to exit:
```

After pressing **<Enter>**, the Surgery software prompts for an additional comment. Nurse Montpelier does not want to add a comment to the report, so she proceeds to sign the report.

Example: Electronically Signing the Nurse Intraoperative Report

```
Do you want to add a comment for this case? NO//<Enter> NO

Enter your Current Signature Code:    SIGNATURE VERIFIED..

Press RETURN to continue...
```

When Nurse Montpelier types the signature code, no characters display on the screen.

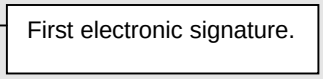
Had both Nurse Lansing and Nurse Montpelier already signed their respective reports prior to editing the OP DISPOSITION field, an addendum would have been required for both reports.

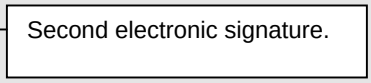
Example: Creating an Addendum

```
 HAWAII,LOU (502-12-1148P)   Case #202 - JAN 18,2002

An addendum to each of the following electronically signed document(s) is
required:

          Nurse Intraoperative Report - Case #202
          Nurse Intraoperative Report - Concurrent Case #203

If you choose not to create an addendum, the original data will be restored
to the modified fields appearing on the signed reports.


Create addendum? YES// Y
```

Nurse Montpelier signs for each addendum individually.

```
Addendum for Case #203 - JAN 18,2002
Patient: HAWAII,LOU (502-12-1148P)
------------------------------------------------------------------------------

The Postoperative Disposition field was changed
  from <NOT ENTERED>
    to WARD

Enter RETURN to continue or '^' to exit: <Enter>




Do you want to add a comment for this case? NO// <Enter>  NO

Enter your Current Signature Code:    SIGNATURE VERIFIED..

Press RETURN to continue...

[SREEN CLEARS]


Addendum for Case #203 - JAN 18,2002
Patient: HAWAII,LOU (502-12-1148P)
------------------------------------------------------------------------------

The Postoperative Disposition field was changed
  from <NOT ENTERED>
    to WARD

Enter RETURN to continue or '^' to exit: <Enter>

Do you want to add a comment for this case? NO// <Enter>  NO

Enter your Current Signature Code:    SIGNATURE VERIFIED..

Press RETURN to continue...
```





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Uploading Operation and Procedure Reports

Facilities using TIU's Document Upload utility will want to work with their Transcription Services and Vendors to implement the upload for dictated Operation and Procedure Reports using captioned headers as described in the following sections.

Reviewing Document Definitions

TIU stores the electronically signed reports and manages the documents. CPRS allows the electronic surgery reports to be viewed via the Reports tab, and a new Surgery tab.

A standard Surgery document hierarchy in TIU is available with this project release, and is also documented in the *Surgery Electronic Signature for Operative Reports Installation Guide.*

Clinical Documents	
Surgical Reports	Class
Operation Report	Document Class
Operation Report	Title
Nurse Intraoperative Report	Document Class
Nurse Intraoperative Report	Title
Anesthesia Report	Document Class
Anesthesia Report	Title
Procedure Report (NON-O.R.)	Document Class
Procedure Report	Title

Operation Reports

The following fields are required for uploading documents: PATIENT SSN, OPERATION DATE, DICTATED BY, ATTENDING SURGEON, and DICTATION DATE. When a report is uploaded, TIU will identify the patient by the Social Security Number, and will then try to identify the case by the surgical case number for the specific date provided. However, for cases where the patient has multiple cases on the same day, or no surgical cases are found for the date specified, a filing error occurs. Then, alerts are sent to the recipients that were specified during setup for the document parameters for the Class Surgical Reports.

Other optional fields may also be included in the header, and may help determine the to which case the document should be filed. For example, including the PATIENT NAME, the TIU DOCUMENT NUMBER, or the Surgery CASE NUMBER may help resolve filing errors.

The following is an example of a header for an Operation Report; note that it does contain more fields than are required for an upload.

Example: Setting up the Operation Report Header

```
$HDR:                   OPERATION REPORT
PATIENT NAME:           GEORGIA,PAUL
PATIENT SSN:            555-12-3445
OPERATION DATE:         02/22/2002
DICTATED BY:            TULSA,LARRY
ATTENDING SURGEON:      TOPEKA,MARK
URGENCY:                ROUTINE
DICTATION DATE:         02/22/2002
TRANSCRIPTIONIST:       T1212
$TXT
```

Optional fields

The DICTATED BY and ATTENDING SURGEON fields are required for uploading; if the same name applies to both fields, then the header should contain the name in each field. If the fields are uploaded without data, in that case, the document will not be marked COMPLETE when it is electronically signed.

When a filing error occurs, it can be readily resolved, as shown below.

Example: Viewing a Filing Error

```
   1      Upload Documents
   2      Help for Upload Utility

FILING ERROR: OPERATION REPORT  Record could not be found or created.
          Enter  "VA   VIEW ALERTS     to review alerts

Select Upload Menu Option: VA  View Alerts


 1.   FILING ERROR: OPERATION REPORT  Record could not be found or created.
          Select from 1 to 1
          or enter ?, A, F, S, P, M, R, or ^ to exit: 1
```

```
The header of the failed record looks like this:

$HDR: OPERATION REPORT
PATIENT NAME: UTAH,JOHNNY
PATIENT SSN: 582-12-9623
DOCUMENT NUMBER: 5778065
SURGICAL CASE: 267228
OPERATION DATE: 02/12/2002
DICTATED BY: BOSTON,LAURA
ATTENDING SURGEON: BOSTON,LAURA
URGENCY: ROUTINE
DICTATION DATE: 02/14/2002
TRANSCRIPTIONIST: R8877
$TXT

Inquire to patient record? YES// <Enter>
Select PATIENT NAME: UTAH,JOHNNY  UTAH,JOHNNY        6-23-59    582129622     NO
 NON-VETERAN (OTHER)    BO/

     1   101944  OPERATION REPORT  Dated: 02/05/2002@10:15    By: ALBANY,R
     2   101944  OPERATION REPORT  Dated: 02/12/2002@08:15    By: BOSTON,L
CHOOSE 1-2: 2  OPERATION REPORT    Dated: 02/12/2002@08:15    By: BOSTON,L

DOCUMENT TYPE: OPERATION REPORT         PATIENT: UTAH,JOHNNY
  VISIT: FEB 20, 2002@17:46:34          PARENT DOCUMENT TYPE: OPERATION REPORTS
  STATUS: UNTRANSCRIBED
  EPISODE BEGIN DATE/TIME: FEB 20, 2002@17:46:34
  VISIT TYPE: E                         ENTRY DATE/TIME: FEB 20, 2002@17:46:34
  AUTHOR/DICTATOR: BOSTON,LAURA         EXPECTED SIGNER: BOSTON,LAURA
  ATTENDING PHYSICIAN: BOSTON,LAURA     REFERENCE DATE: FEB 12, 2002@08:15
  ENTERED BY: JER                       CAPTURE METHOD: remote procedure
  DICTATION DATE: FEB 22, 2002@16:05    SERVICE: INFORMATION RESOURCE MGMT
  REQUESTING PACKAGE REFERENCE: UTAH,JOEL
  COSIGNATURE NEEDED: NO
  SUBJECT (OPTIONAL description): Case #: 267228
  VISIT ID: M76NF-BOS

... OK? YES// <Enter>

Filing Record/Resolving Error...Done.


Continue (Y/N) or (F)orward or (R)enew YES// <Enter>


   1      Upload Documents
   2      Help for Upload Utility

Select Upload Menu Option:
```

Note that in the case described above, the filing error is resolved simply by selecting the correct Operation Report. No changes to the header of the uploaded document are needed to resolve the error.

Procedure Reports (Non-O.R.)

Facilities using the Non-O.R. Procedures module of the Surgery software will now be able to upload the Clinician's reports for such cases using the following captioned header.

Example: Setting up the Procedure Report (Non-O.R.) Header

```
$HDR:                          PROCEDURE REPORT
PATIENT NAME:                  GEORGIA,PAUL
PATIENT SSN:                   555-55-5555
OPERATION DATE:                02/22/2002
DICTATED BY:                   TULSA,LARRY
ATTENDING PHYSICIAN:           TOPEKA,MARK
URGENCY:                       PRIORITY
DICTATION DATE:                01/11/2002
TRANSCRIPTIONIST:              T2121
$TXT
```

Requirements for successful filing, as well as the process for resolving filing errors for Procedure Reports, are identical to those for Operation Reports.

Dictation Support

In addition to the changes in support of the TIU Document Upload utility, a new option in the TIU package is provided to support dictation of Surgical Reports. Clinicians may call for a list of their non-dictated documents and also indicate that dictation has been completed, as shown in the following example.

Example: Using the *Clinician's Menu*

```
                          --- Clinician's Menu ---


   1      Progress Notes User Menu ...
   2      Discharge Summary User Menu ...
   3      Integrated Document Management ...
   4      Personal Preferences ...

Select Progress Notes/Discharge Summary [TIU] Option: 3  Integrated Document Management

                          --- Clinician's Menu ---


   1      Individual Patient Document
   2      All MY UNDICTATED Documents
   3      All MY UNSIGNED Documents
   4      Multiple Patient Documents

Select Integrated Document Management Option: 2  All MY UNDICTATED Documents

Searching for the documents.
```

```
UNDICTATED Documents          Feb 22, 2002@16:05:07          Page:    1 of    1
                             by AUTHOR (BOSTON,LAURA)                1 documents
     Patient                Document                          Ref Date  Status   .
1    UTAH,J        (U9622) OPERATION REPORT                  02/12/02  undictated
```

```
          + Next Screen  - Prev Screen  ?? More Actions                  >>>
     Find                      Document(s) Dictated      Change View
     Detailed Display          Print                     Quit
Select Action: Quit// DOC   Document(s) Dictated
```

```
Opening OPERATION REPORT record for review.........

Document Dictated              Feb 22, 2002@16:05:28          Page:    1 of    2
                                OPERATION REPORT
UTAH,J         582-12-9622                          Visit Date: 02/20/02@17:46

  Reference Date: FEB 12, 2002@08:15              Author: BOSTON,LAURA
      Entry Date: FEB 20, 2002@17:46:34        Entered By: JER
 Expected Signer: BOSTON,LAURA          Expected Cosigner: BOSTON,LAURA
         Urgency: None                    Document Status: UNDICTATED
      Line Count: None                     TIU Document #: 5778065
         Subject: CASE #: 267228

Associated Problems     No linked problems.

Edit Information     No edits since entry.

Signature Information
     Signed Date: None                            Signed By: None
                                                 Signature Mode: None
+         + Next Screen  - Prev Screen  ?? More Actions
     Find                       Dictation Finished
     Print                      Quit
Select Action: Next Screen// DIC   Dictation Finished

Has this document been dictated? NO// YES

AUTHOR/DICTATOR: BOSTON,LAURA// <Enter>
DICTATION DATE: NOW// <Enter>  (FEB 22, 2002@16:05)
ATTENDING PHYSICIAN: BOSTON,LAURA// <Enter>

  Dictation data changed.

Updating the list...

UNDICTATED Documents           Feb 22, 2002@16:05:58          Page:    1 of    1
                             by AUTHOR (BOSTON,LAURA)                1 documents
     Patient                Document                        Ref Date  Status   .
1    UTAH,J        (U9622) OPERATION REPORT                 02/12/02  untranscri









          + Next Screen  - Prev Screen  ?? More Actions                    >>>
     Find                       Document(s) Dictated      Change View
     Detailed Display           Print                     Quit
Select Action: Quit//
```

Glossary

The following table provides definitions for common terms used in this manual.

Term/	Definition
Addenda	More than one addendum.
Addendum	A document attached to an original report, which records changes made by a provider to a patient's case. An addendum is required after a report has been electronically signed.
Case	All of the information related to a procedure.
Class	Part of Document Definitions, Classes group documents. For example, "Progress Notes" is a class with many kinds of progress notes under it.
Completed Case	Case status indicating that an entry has been made in the TIME PAT OUT OR (#.232) field.
Concurrent Case	A patient undergoing two operations by different surgical specialties at the same time, or back-to-back, in the same operating room.
Object	Objects are a device to extract data from other **V*IST*A** packages to insert into boilerplate text of progress notes or discharge summaries.
Screen Server	A format for displaying data on a cathode ray tube display. Screen Server is designed specifically for the Surgery package.
Screen Server Function	The Screen Server prompt for data entry.

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